Portfolio Review of USAID/El Salvador Health Office

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ACRONYMS

ANDA	National Aqueducts And Sewerage Administration
BASICS	USAID/W Project
CA	Cooperating Agency
CDC	Centers For Disease Control
CIMR	Interagency Committee For Modernization And Reform
CHANGE	USAID/W Project
COSIN	Communication For Child Health
CMR	Child Mortality Rate
CPR	Contraceptive Prevalence Rate
C Sections	Cesarean Sections
CSW	Commercial Sex Worker
CTU	Contraceptive Technology Update
CYP	Couple Years Of Protection
D&C	Dilation And Curettage
DELIVER	USAID/W Project
DHF	Dengue Hemorrhagic Fever
DIGESTYC	General Direction Of Statistics And Census
DOTS	Directly Observable Treatment
DPT3	Three Doses Of Diphtheria, Pertussis (Whooping Cough) And Tetanus
EHP	Environmental Health Project
FESAL	EL Salvador Demographic And Health Survey
FP	Family Planning
GDP	Gross National Product
GOES	Government Of El Salvador
IMCI	Integrated Management Of Childhood Illness
IMR	Infant Mortality Rate
IR	Intermediate Result
ISS	Social Security Institute
MCH	Maternal And Child Health
MOH	Ministry Of Health
MOST	USAID/W Project
MSH	Management Science For Health
MSM	Men Having Sex With Men
MVA	Manual Vacuum Aspiration
MWRA	Married Women Of Reproductive Age
NEPRAM	Negotiation For Improved Practices
PAC	Postabortion Care
PASMO	Pan American Social Marketing Organization
PCI	Project Concern International
PHRplus	Partners For Health Reform Plus
PRIME	USAID/W Project
RASES	Water And Sanitation Network Of El Salvador
RH	Reproductive Health
SALSA	Healthy Salvadorans
SIBASI	Basic Systems of Integrated Health
SIDA	AIDS In Spanish
SO	Strategic Objective
SOAG	Strategic Objective Agreement Grant
SSO	Special Strategic Objective
SOW	Scope Of Work
STI	Sexually Transmitted Infection

TBCTA	Tuberculosis Coalition For Technical Assistance
TFR	Total Fertility Rate
VNC	Voluntary Nutrition Counselors
VSC	Voluntary Surgical Contraception

EXECUTIVE SUMMARY

This report presents a review of the portfolio of the Health Office of USAID/El Salvador (USAID/PHN). The review was undertaken by a team of six persons, led by an independent consultant for POPTECH, with one senior public health specialist retired from USAID and four current USAID staff from Global Health on the Review Team.

The USAID/PHN designed its portfolio within the strategic context of the Mission's plan, *Sustainable Development & Democracy in El Salvador 1997-2002,* with a customer focus on the rural poor. The Office has revised, adapted and implemented the portfolio within the context of Hurricane Mitch in 1998, two earthquakes in 2001 and a dengue epidemic in 2002, all in a country recovering from a devastating civil war.

On July 30, 1998, USAID and the government of El Salvador (GOES) signed the strategic objective grant agreement (SOAG) for the Strategic Objective (SO) "Sustainable Improvements in the Health of Women and Children Achieved." In August 2002, the SO name was amended to read "Health of Salvadorans, primarily Women, Youth and Children, Improved" and the agreement was extended to June 2005. The purpose of the SO is to improve the quality and access to child survival services and reproductive health care for Salvadorans, primarily the rural poor, and to improve the policy framework and strengthen the institutions that support and sustain these interventions. There are two Intermediate Results (IRs): 1) Access to Quality Health-Related Services Increased and 2) Use of Health-related Services/Practices Increased.

The scope of the portfolio is broad, with five major components, and the matrix of management relations is complex, with two major national partners, the Ministry of Health (MOH) and the Salvadoran Demographic Association (SDA). Within the MOH, USAID relates to at least five different offices (gerencias); eight Cooperating Agencies (CAs) provide technical support through field support mechanisms and through contracts with the Mission. Additionally, USAID/Washington has seven core-funded activities in El Salvador, implemented through an additional five CAs. The management burden is very considerable.

The five major components are:

- Child Survival, which includes water and sanitation
- Reproductive Health
- Prevention of sexually transmitted diseases and HIV/AIDS
- Other infectious diseases, such as dengue and tuberculosis
- Policy and health system modernization

Many activities within these components have been national in scope, with the potential to significantly improve maternal and child health. For instance, with the health promoter, who is key to improved rural health, the MOH and USAID have upgraded and redefined their role, trained 100% in Integrated Management of Childhood Illness (IMCI), emphasized breastfeeding, and are assessing how to best support their work in community-based distribution of contraceptives. USAID has provided contraceptives to the MOH and SDA and funding for outreach and services for the rural poor. The MOH and USAID have developed and disseminated protocols and standards and trained staff in aspects of neonatal care, IMCI, and family planning. With HIV/AIDS, USAID has held up best practices and lessons learned around the world to contain the epidemic and prevent its spread from "bridge" populations into the general population.

The Office's portfolio also includes important innovative work on a pilot basis. "Adolescent friendly services" in three departments have been successful in drawing adolescents into the formal sector for care.

Improved postabortion care in five departments has provided women with a less invasive procedure for treatment of complications and reduced hospital stays, while lowering hospital costs. Efforts to lower the high rate of caesarean sections during child birth have been successful, as have efforts to make an episitomy, dreaded by adolescents and one factor in their reluctance to deliver in a hospital, more elective.

USAID has also been responsive to El Salvador's natural disasters and emergencies, the most recent of which is dengue.

Health sector reform is one component of the portfolio and this report identifies USAID as an honest broker in El Salvador. USAID's approach has been that of an independent source of technical assistance, not trying to sell any particular agenda; this approach allows USAID to modify its support as the country continues to refine its vision for the health sector. The MOH's current development hypothesis is that efforts to strengthen access and to improve use and health practices can best be accomplished through the development of SIBASIs – Sistemas Basicos de Salud Integral. The MOH has divided the fourteen departments of El Salvador into 28 SIBASIS and has assigned USAID the lead role in seven of them. In June 2002 the Ministry of Health made a major decision to make all health services at the primary level free of charge. This decision has great implications for the delivery and financing of all public health care. The SIBASI model as currently envisioned does not tackle the difficult issue of how to sustainably finance health care for the rural poor.

The MOH and USAID/PHN have accomplished a great deal in recent years, the impact of which will be seen in the upcoming Health and Demographic study (FESAL) in 2003. Challenges remain; they include:

- Seizing the window of opportunity (March-November 2003) to establish a legal framework for the SIBASIs;
- Balancing USAID support for the SIBASI model while urging the GOES to consider and address possible drawbacks of this model;
- Expanding water and sanitation for the rural poor beyond the current coverage of 27%;
- Ensuring contraceptive security during and after phase out, including continued community-based distribution (CBD) through promoters
- Supporting health promoters so that they have realistic workloads, are fully equipped and supplied with the essentials for their job, including contraceptives, and are appropriately supervised;
- Building upon the good start in community IMCI (training of promoters) by ensuring the promoters apply the protocols correctly (supervision) and making significant progress in clinical IMCI;
- Reducing malnutrition among children under two years and pregnant women through nationwide training and monitoring of nutrition volunteers;
- Reducing neonatal mortality through successful nationwide implementation and monitoring of the "mother-baby package';
- Making progress, beyond the plateaued rate of the last six years, in the percent of deliveries by skilled providers, by taking advantage of nurses, unidades de salud and casas de salud;
- Meeting the unmet need of the rural poor and adolescents for family planning;
- Taking the reproductive health innovations piloted in a few departments to scale;
- Conveying a sense of urgency and opportunity (targeting high-risk groups) with HIV/AIDS; and
- Offering adolescent girls an alternative to early pregnancy and motherhood.

The Review Team affirms the Mission' customer focus on the rural poor. Health status, as noted throughout this report, is markedly worse among the rural population than it is for the urban population:

- Only 27% have adequate access to potable water (urban 83%);
- 8% of children < 5 years are severely malnourished (urban 3%);
- neonatal mortality rate is 41 per thousand (urban 27);
- unmet need for family planning is 12% (urban 5%); and

- only 43% of women deliver in a hospital (urban 78%).

There are recommendations, for the last year and a half of this strategy and for the longer term, in each section of the report. The list below summarizes those recommendations.

List of Recommendations by Program Area

Activity Performance

1. Include periodically other key Unit staff in the monthly meetings between the SALSA Coordinating Unit Administrative Director and USAID/PHN, to broaden the understanding and management of the SALSA project;
2. Review SALSA staffing requirements and adjust as needed, with particular attention being paid to the legal framework and staffing required for SIBASI program management and implementation; and
3. Continue to monitor process indicators and carefully study data from the upcoming FESAL 2003 and revise activities accordingly.

Policy and Reform

1. Fund a FESAL equity study: an analysis of FESAL findings by income quintiles (disaggregated if possible between urban and rural), if it is possible to construct an asset index or another proxy of income levels from the questionnaire;
2. Provide technical assistance to the GOES on National Health Accounts to enable earlier publication and to enhance use for policy making;
3. Ensure SIBASI accountability to the community, drawing on other precedents, as appropriate, for lessons on how to make social services accountable to community groups;
4. Establish legal foundations for modernization of the MOH and the creation of the SIBASIs; seize the window of opportunity for introducing the new Health Code between March-November 2003;
5. Pursue health care financing to ensure that poor rural underserved Salvadorans have better access to and use of health services and practices; develop viable options for sustainable financing for health care for the rural poor;
6. Provide technical assistance to the GOES on targeting public spending on health and on the development of resource allocation mechanisms that incorporate indices of need;
7. Support the MOH's improving its strategic communications about its priorities, accomplishments and aims, including its efforts to take care closer to those in need;
8. Support health system (MOH and social security) integration: maintain focus on the need for integrating the whole health system;
9. Foster horizontal interaction among SIBASIs, enabling dissemination of best practices among SIBASIs through horizontal mechanisms independent of the central MOH; and
10. Provide incentives for SIBASI experimentation and excellence.

Environmental Health

1. Consider adjustment of program indicators in the next strategy to better reflect the combination of hygiene behavior needed to achieve a sustainable impact on health outcomes;
2. Increase internal coordination between the two USAID projects, both within USAID and CARE, as mentioned in the Program Description for Water, Sanitation for Health Activity;
3. Move toward one integrated, comprehensive USAID/El Salvador water and sanitation program;
4. Increase external coordination with other donors about their objectives, plans, and geographical focus over the next period;
5. To build sustainability, develop a strategy for ongoing technical support for water committees;
6. Continue to strengthen the system of local health promoters and health committees;

7. Promote human resources development, including updating the curriculum for engineers in comprehensive and innovative approaches to water and sanitation;
8. Employ strategic approaches for men and women;
9. Focus on specific targeted behavior changes; and
10. Continue collaborating on a unified educational approach for water and sanitation.

Infant and Child Health

1. Analyze the rural nutrition centers to determine if their primary use is health or early childhood education; if it is early childhood education, consider if USAID's Office of EGE could take the lead in assisting these centers;
2. Establish nutritional sentinel sites to monitor nutrition among acutely vulnerable populations;
3. Continue to provide high level support and continuous efforts to promote breastfeeding at the hospital level and with health promoters, nutritional volunteers, and parteras;
4. Continue development of IMCI, ensuring that promoters correctly apply the protocols they have learned (community IMCI) and strengthening those clinical areas that are relatively underdeveloped, as identified in the recent evaluation (clinical IMCI);
5. Continue to train health personal in neonatal care and reach goal of one trained person in each hospital/health unit in which deliveries take place;
6. Provider greater support, supervision and monitoring for the promoters: ensure that they have a "doable" workload; consider creating an oversight office in the MOH for promoters; and
7. Consider adding a birth spacing activity in the new strategy.

Reproductive Health

1. Deepen USAID/MOH/UNFPA discussions on contraceptive security and build a clear understanding of UNFPA's plans, including both a timetable and resource allocation for contraceptive security;
2. Strengthen the direction (norms, standards, policies) and supervision supporting the promoters' provision of counseling, orals, condoms and injectables in the community - make successful CBD a priority and significantly reduce rural unmet need for family planning;
3. In line with strengthened direction and supervision, ensure smooth, reliable and adequate contraceptive supply and broad method-mix in the SIBASI agreements, at least in the seven USAID-focus SIBASIs, including reliable and adequate stocks at the community level;
4. Continue efforts to promote the IUD as a safe, effective and satisfactory method of long-term contraception;
5. Develop and implement strategic plan for scaling-up PRIME successes in improved quality of reproductive health care (adolescent reproductive health, EOC, PAC and other improved hospital care etc.) to the new seven USAID-focus SIBASIs;
5. Develop and implement plans, at least on a pilot basis, for training appropriate nurses in obstetrics and for equipping Unidades and Casas de Salud for deliveries;
6. Undertake follow-up study on client satisfaction with contraception;
7. Intensify efforts with Unidades, promoters, parteras and communities on effective referral systems and delivery plans that realistically link women with trained providers, including means of transport and payment of fees;
8. Convene all donors for RH in the 28 SIBASIs, map out national coverage and goals, plan collaboration and sharing of lessons learned and progress made;
9. Share (with El Salvador RH community) the MOH/PRIME lessons learned in the reproductive health innovations in improved quality of care (reduced rate of cesarean sections, comprehensive postabortion care, EOC, COPE);
10. Consider selective support of SDA, in light of its contribution to the national program (reproductive care, as a center of excellence in research and advocacy);

11. On an on-going basis, prioritize activities in terms of their contribution to USAID/El Salvador objectives and to the national program; drop those programs such as cervical cancer that do not contribute to USAID's SO;
12. Evaluate proposals for new core-funded activities in terms of whether they will have a direct and considerable impact upon achievement of the USAID/El Salvador PHN SO;
13. In light of the existing heavy management burden in reproductive health, consider that burden when making decisions about focus, scale-up and expansion of reproductive health activities.

HIV/AIDS

1. Prioritize the implementation of a strengthened/expanded surveillance system with the MOH and make the monitoring of the epidemic in groups who practice "high-risk" behavior a priority;
2. Develop and implement a plan for dissemination of important results regarding HIV/AIDS to increase stakeholder support;
3. Seek out where there is common ground between USAID and the MOH and develop a clear, realistic work plan for 2 years with the limited funds available on areas that can be mutually agreed upon;
4. Continue to strengthen local NGOs (institutionally and organizationally) especially in their ability to expand their donor base and to promote their institutional financial sustainability;
5. As a priority, enable PASMO to reach greater numbers of high risk behavior groups during the next 2 years by expanding PASMO staff and including a "night shift"; and
6. Share the upcoming baseline survey data to build stakeholder support for the planned behavior change interventions.

Dengue Prevention

1. Consider inclusion of a behavior change indicator for dengue control in the USAID results framework;
2. Consider a no-cost project extension to demonstrate a cost-effective, community based approach to behavior change at the community level as well as institutionalization within the MOH;
3. Finalize the evaluation protocol with clear and measurable behavioral and entomological objectives at both the community and institutional levels;
4. Ensure solid documentation of entomological data (change in number of larvae) and behavioral indicators;
5. Work closely with the MOH staff that has been trained; and
6. Strengthen the environmental health component of the project.

Adolescents

1. Fund the MOH-developed manuals that have also been endorsed by the Ministry of Education and the National Secretariat for the Family;
2. Include "adolescent friendly services" in the seven USAID-focus SIBASIs;
3. Find a way to evaluate the SDA adolescent program; and
4. In the next strategy, consider investments that give poor rural girls a vision of a better life – more schooling or vocational education - a chance to "get a life".

Promoters

1. Pursue the need for additional supervisors and ensure that supervisors are adequately supervised**;**
2. Review system for equipment distribution, including motorcycles to supervisors;
3. Evaluate the workload of the health promoter and prioritize to ensure compliance with essential tasks (e.g. family planning,maternal and child health and maintaining accurate records of mortalities);
4. Ensure that all promoters have been trained in family planning counseling and provision and that all have adequate supplies of temporary methods and know where to refer for permanent methods; and

5. Provide greater support (design of referral systems, training, supervision and IEC materials) to promoters on maternal health so they might be effective agents working to increase the percentage of deliveries by training providers.

Rural Poor

1. Share important MOH/PRIME/BASICS lessons learned in Sonsonate, one of the poorest departments in the country with health staff in the seven USAID-focus SIBASI;
2. Share lessons learned about targeting the rural poor in the seven SIBASIs with the MOH, the other twenty-one SIBASIs and other donors; and
3. In a future Mission strategy, should the Mission reaffirm a customer focus on the rural poor, consider a realignment of SIBABIs among donors so that USAID might more fully focus its efforts in health on the rural poor.

1. INTRODUCTION

1.1 This Report

At the request of USAID/El Salvador, a team of six people undertook a portfolio review of USAID's health assistance to El Salvador. The Review Team consisted of Laurel Cobb, team leader, and Michael Jordan, both independent consultants hired by POPTECH, and Karen Cavanaugh, Merri Weinger, and Mary Vandenbroucke of USAID/Global Health, and John Austin (USAID/Global Health) who was a virtual team member. See Scope of Work (SOW) in Annex A.

Data for this report came from an extensive review of documents (see bibliography in ANNEX B), interviews with USAID/El Salvador staff, staff with cooperating agencies (CAs), Ministry of Health (MOH), other key informants, providers (doctors, nurses, midwives, and promoters) and through field visits to health facilities on two days. See ANNEX C for a list of persons consulted.

This document presents questions from the SOW in indented ***bold, italics***. The Review Team's response to those questions follows in indented normal font. The source for data in all TABLES is the 1998 El Salvador Health and Demographic report (FESAL), unless other wise noted.

1.2 USAID/El Salvador PHN

The Review Team wishes to express its appreciation to, and admiration of, the PHN staff. They were most hospitable to the Team; more importantly, they have accomplished a great deal under the constraints of hurricanes, earthquakes and epidemics. The plaques on their office walls testify to their contributions to health, USAID and El Salvador over the last years.

2. BACKGROUND

2.1 Civil war

In 1998, the start point of activities in this review, El Salvador was "poised at the beginning of a new chapter in its history." It was to be a chapter "holding the promise of deepened democratic values, enlightened social awareness, comprehension of the importance of the environment and sustainable economic growth." The civil war had ended six years previously. "The primary U.S. foreign policy objective in El Salvador was the consolidation of peace in a democratic society." [1]

2.2 USAID/El Salvador Strategic Plan, 1997-2002

2.2.1 The Strategy

USAID/El Salvador's plan, *Sustainable Development & Democracy in El Salvador 1997-2002* presents four strategic objectives (SO) and one special strategic objective (SSO).[2]

- "**SSO War-to-Peace** will complete activities and achieve results set out in the prior strategy for El Salvador's war to-to-peace strategy. This SSO responds to the Agency's goal to save lives, reduce suffering and reinforce potential for development.[3]

[1] *Sustainable Development & Democracy in El Salvador 1997-2002,* May 1996
[2] IBID pages 15-16
[3] This SSO ended in 1997

- **SO Economic Opportunity** will expand access and opportunity for the poor, in support of the Agency's goal to achieve broad-based economic growth.
- **SO Democracy** will strengthen accountability to citizens by local government, judicial and electoral institutions to foster the goal of building sustainable democracies.
- **SO Health** focuses on improving the health status of children and mothers. This SO supports the goal of stabilizing growth and protecting human health.
- **SO Environment** will work for adoption of environmentally sound practices, in pursuit of the Agency's goal of managing the environment for long-term sustainability."[4]

Additionally, during the strategy period, USAID included two additional Special Objectives. There was one for Hurricane Mitch from 1999-2001. The second, for Earthquake Reconstruction, was initiated in 2001 and will continue until 2004.

2.2.2 USAID/El Salvador Customer Profile

Sustainable Development & Democracy in El Salvador 1997-2002 states "The Mission is targeting as its customers Salvadorans in rural areas living in poverty, both relative and extreme. Mission programs will improve living conditions for both men and women. However, this strategy gives particular emphasis to programs affecting women, youth and children."

The Mission's Plan further defined the general profile of the customer. "The Mission's strategy will focus on the areas of the country where the neediest customers are concentrated. In these 'sustainable development areas', the efforts of SO teams and of USAID's partners will be effectively coordinated to address customer needs. The poverty focus does not preclude interventions at the national or wider regional level. It does indicate, however, that the SOs will seek to maximize results in the areas identified."[5]

3. PORTFOLIO DESIGN

3.1 Strategic Framework

On the following page is the final 2002 version of the USAID Health Strategic Framework. There are two intermediate results to achieve the SO, "Health of Salvadorans, Primarily Women, Youth and Children Improved."

1. Access to Quality Health-Related Services Increased
2. Use of Health-related Services/Practices Increased

3.2 SALSA

On July 30, 1998, USAID and the government of El Salvador (GOES) signed the SO grant agreement (SOAG) for the SO "Sustainable Improvements in the Health of Women and Children Achieved" and to fund the Healthy Salvadorans (SALSA) Activity No. 519-0430. In August 2002, the SO name was amended to read "Health of Salvadorans, primarily Women, Youth and Children, Improved". "The purpose of these activities and the Agreement is to improve the quality and access to child survival services and reproductive health care for Salvadorans, primarily the rural poor, and to improve the policy framework and strengthen the institutions that support and sustain these interventions."[6] The SALSA activity has the following components

[4]Later revised to sharpen the focus; now the statement includes watershed protection, provision of clean water, and education campaigns on water and hygiene
[5] IBID page 16
[6] Amendment No.9 page 6

- Child Survival
- Reproductive Health, that includes support to the Salvadoran Demographic Association (SDA)
- Prevention of sexually transmitted diseases and HIV/AIDS
- Other infectious diseases, such as dengue and tuberculosis
- Policy and health system modernization

USAID/PHN has funded a sixth component, water and sanitation, through the Public Services Improvement Project 519-0320. When it comes to an end in 2003, activities will come under SALSA.

3.3 Natural Disasters

Since the SALSA activity agreement was first signed in 1998, El Salvador has suffered one hurricane, two earthquakes and a dengue epidemic.

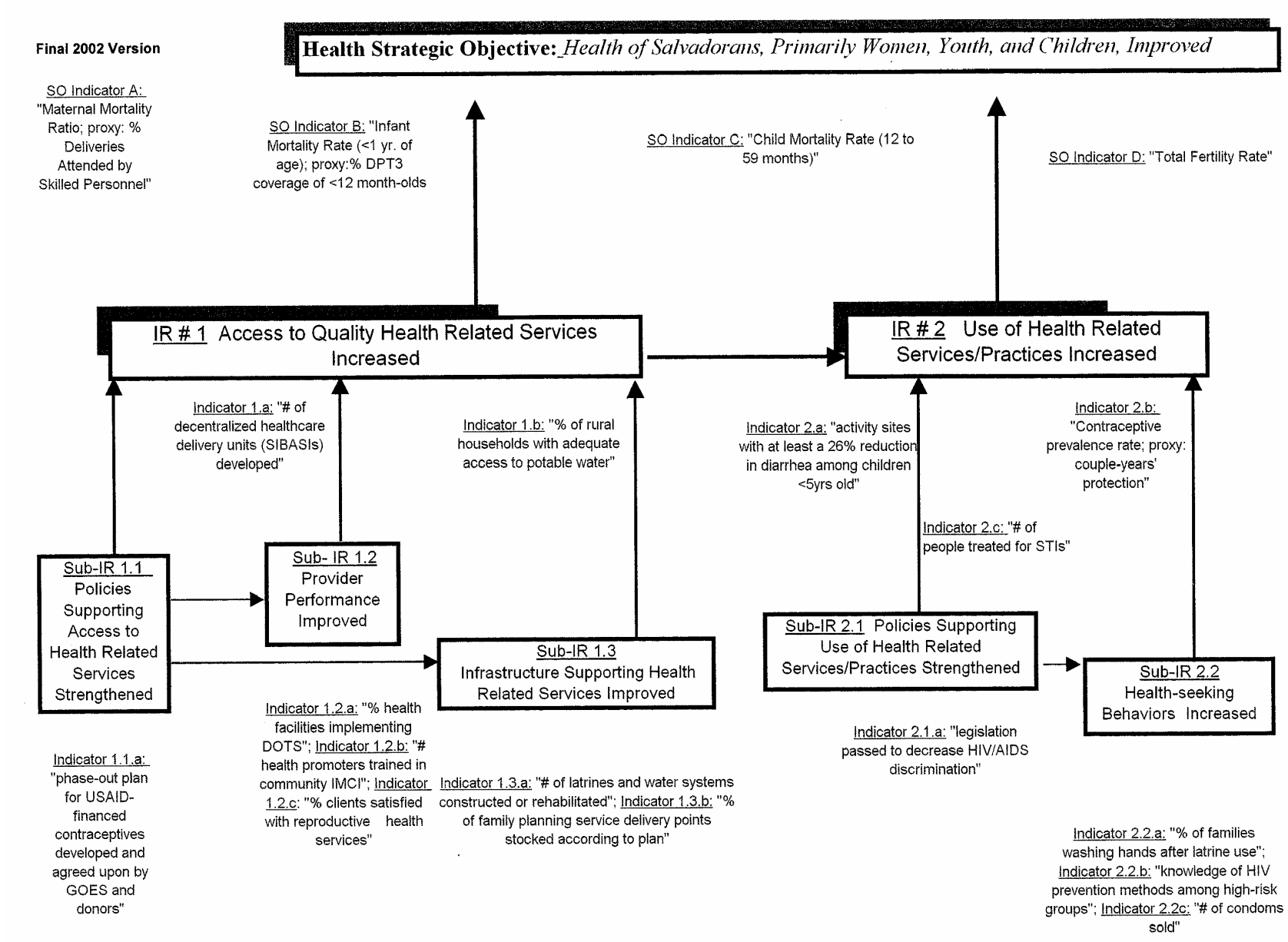
- **Hurricane Mitch of October 1998.** The flooding and landslides of Hurricane Mitch resulted in 374 persons killed and 55,864 displaced. Twelve of the country's 14 departments suffered significant damage; roughly 163,000 acres were flooded, and 15 major bridges were damaged or destroyed. The GOES estimated the total damage at $132.5 million. The flooding was felt most in rural areas, particularly in the departments of San Vicente, Usulutan and San Miguel -- some of the poorest parts of the country. These were also areas where people affected by the war had been recently resettled, ex-combatants had been given land, and where many land reform cooperatives are located."[7]
- **Earthquakes of January and February 2001.** Two major earthquakes, measuring 7.6 and 6.6 on the Richter Scale, struck the country and killed 1,159 people and injured another 8,122. Economic losses were estimated to be close to $2 billion. 1.5 million Salvadorans, or one quarter of the population, were affected. The social infrastructure was especially hard hit: 149,528 homes were destroyed and 185,338 were damaged. 141 health facilities, including hospitals, clinics, laboratories and nutrition centers were either partially or totally destroyed.[8],[9]
- **Dengue Epidemic of 2002.** In 2002 dengue worsened in El Salvador; combating the disease became a national priority. In June, the President of El Salvador declared a state of emergency in the departments of San Salvador, Libertad, Santa Ana, and Cabañas, and a yellow alert in the rest of the country. Eventually the epidemic was declared nationwide.

3.4 Linkages between Activity Objectives and IRs

Are the activity objectives directly linked to the intermediate results? If so, then, are the activity inputs appropriate for achieving activity objectives?

Almost all the activity objectives are directly linked to the IRs.[10] They are appropriate (necessary); perhaps the more important question is whether they are sufficient. Each section of the report addresses this question.

[7] http://hurricane.info.usaid.gov/reports/elsalv.html
[8] *Special Objective: Lives of Targeted Earthquake Victims Improved*
[9] There is loan funding for reconstruction of hospitals.
[10] The exceptions would be cervical cancer and a number of the core-funded activities.


Final 2002 Version
Health Strategic Objective: Health of Salvadorans, Primarily Women, Youth, and Children, Improved
SO Indicator A: "Maternal Mortality Ratio; proxy: % Deliveries Attended by Skilled Personnel"
SO Indicator B: "Infant Mortality Rate (<1 yr. of age); proxy:% DPT3 coverage of <12 month-olds
SO Indicator C: "Child Mortality Rate (12 to 59 months)"
SO Indicator D: "Total Fertility Rate"
IR # 1 Access to Quality Health Related Services Increased
IR # 2 Use of Health Related Services/Practices Increased
Indicator 1.a: "# of decentralized healthcare delivery units (SIBASIs) developed"
Indicator 1.b: "% of rural households with adequate access to potable water"
Indicator 2.a: "activity sites with at least a 26% reduction in diarrhea among children <5yrs old"
Indicator 2.b: "Contraceptive prevalence rate; proxy: couple-years' protection"
Indicator 2.c: "# of people treated for STIs"
Sub-IR 1.1 Policies Supporting Access to Health Related Services Strengthened
Sub- IR 1.2 Provider Performance Improved
Sub-IR 1.3 Infrastructure Supporting Health Related Services Improved
Sub-IR 2.1 Policies Supporting Use of Health Related Services/Practices Strengthened
Sub-IR 2.2 Health-seeking Behaviors Increased
Indicator 1.1.a: "phase-out plan for USAID-financed contraceptives developed and agreed upon by GOES and donors"
Indicator 1.2.a: "% health facilities implementing DOTS"; Indicator 1.2.b: "# health promoters trained in community IMCI"; Indicator 1.2.c: "% clients satisfied with reproductive health services"
Indicator 1.3.a: "# of latrines and water systems constructed or rehabilitated"; Indicator 1.3.b: "% of family planning service delivery points stocked according to plan"
Indicator 2.1.a: "legislation passed to decrease HIV/AIDS discrimination"
Indicator 2.2.a: "% of families washing hands after latrine use"; Indicator 2.2.b: "knowledge of HIV prevention methods among high-risk groups"; Indicator 2.2c: "# of condoms sold"

3.5 Articulation of Activity Elements

Do the activity goal and objectives have indicators that enable measurement/assessment of their accomplishments? Are the inputs and outputs specified in quantitative and qualitative terms, with a reasonable and realistic timeframe for their delivery/production?

The USAID/PHN has been working on "Performance Data Tables" that clearly present a framework of assessing accomplishment.[11] With these Tables, the USAID/PHN has made great progress in specifying expected outcomes. However, with Amendment No. 9 and its focus on seven SIBASIs further work is required, to define how health status is expected to improve in these areas in which USAID is focusing. Moreover, USAID inputs, focused on seven SIBASIs with 19% of El Salvador's population, are likely to show impact on a regional or SIBASI level. Significant reduction in maternal, infant or child mortality on a national level will require success as well with the other 81% of the country's population. The strategic framework (plan) should identify the other donors/players who are essential to improving the health of Salvadorans, primarily women, youth and children; it should provide a basis for collaboration and dialogue on interventions to maximize impact. The need for clarity about the role and contribution of other donors is particularly acute in El Salvador now, with the MOH's assignment of a lead role in each SIBASI to different donors.

3.6 External Factors

Are the activity designs realistic taking into account the current social/political/economic conditions of the country?

Several external factors will impinge upon the success of this SO. First, both the World Bank and DIB have pending loans for health services. The World Bank has proposed a $167 million health loan for reconstructing seven large MOH hospitals and for contracting health services for 350,000 rural poor people in municipalities in the departments of Cabanas, Chalatenango, La Union, Morazan, San Miguel and Santa Ana. The IDB has a $20.7 million health loan for reconstructing 40 health centers and for contracting health services for 200,000 to 250,000 rural poor. The success of these loans is critical both to national impact and to achieving improved health status for the rural poor, USAID's customers. Secondly, as is mentioned throughout this report, there will be a relatively short "window of opportunity" during which time the legal foundations for health reform must be established. Should a legal basis not be established during this time, considerable investment may be for naught.

4. ACTIVITY PERFORMANCE

4.1 Strategy

Judged on the basis of activity performance, is the strategy appropriate to achieve results in the established timeframe?

The USAID/PHN portfolio is complex with five broad programmatic areas, a dozen lead institutions/contractors, many lesser players, and a multitude of activities, some on a national level and some in discrete geographic areas. Over the timeframe in question, there have been three bilateral agreements, 20 field support agreements with CAs, as well as a number of core-funded activities. The portfolio is that of an integrated program under one SO; good, steady progress is being made in integrating the many elements. It is a gradual process, as USAID has learned throughout the world.

[11] Performance Data Tables, Health of Salvadorans, Primarily Women, Youth and Children Improved, October 28, 2002

TABLE 1: Portfolio Program Areas and Key Partners, Bilateral and Field Support[12]	
Child Survival	• MOH – nationally and in 7 SIBASIs • BASICS – nationally, in 7 SIBASIs and in 3 special implementation areas • MOST –nationwide, plus 5 high-risk communities
Reproductive Health (with six sub-programs)	• MOH - nationally and in 7 SIBASIs • SDA – nationwide, direct service delivery, advocacy, research • PRIME II – nationally, in target departments for RH pilots and in 7 SIBASIs • DELIVER working with MOH, SDA and PRIME
Infectious Diseases, HIV/AIDS, TB	• MOH - nationally • CHANGE (AED) - nationally • TBCTA - nationally • PAHO - nationally • CDC - nationally
Water and Sanitation	• MOH - nationally • CARE/PROAGUAS – in target areas • CARE/PROSPERAR – in target earthquake areas
Policy Reform	• MOH -nationally • Partners for Health Reform Plus (PHR+) - nationally
Dengue	• MOH - nationally • CHANGE – 3 communities • Municipalities – own communities • UNICEF - nationwide

[12] Additionally, there are the following:

USAID/El Salvador List Of USAID/Washington Core-Funded Activities In El Salvador			
Name of the Project	Cooperating Agency	Activity in El Salvador	Local Partner
AWARENESS Natual FP & RH	Georgetown University Medical Center Institute of Rep.Health	Study and implementation of the Standard Day Method of FP ("El Collar") in selected communities	PCI
CTR-Contraceptive Tech. Research	Family Health International (FHI)	Validation of a Survey-Based Approach for Predicting Willingness to Pay for RH Services	SDA
CTR-Contraceptive Tech. Research	Family Health International (FHI)	A Randomized Controlled Trial of Two Vasectomy Techniques	SDA
POLICY II	The Futures Group International (TFGI)	Population Projections and its consequences in social and economical sectors	SDA
CMS-Commercial Mrktng Strategies	Deloitte Touche Tohmatsu	Network of Adolescents Friendly Pharmacies	SDA
CATALYST Consortium	Pathfinder Intl.	South - South Program Implementing a Cost Accounting System for SDA	SDA
Maximizing Access and Quality	Multiple FHI	Training and updates to medical and nursing schools professors in RH norms and selected topics	Multiple (11 Salvadoran organizations)

One clearly advantageous aspect of the strategy has been the use of the five field support mechanisms. They provide technical competence on the ground in El Salvador, working together as a team from the same building. They have good relationships with each other and with USAID.

Were activities undertaken or currently underway that were not specified in activity documents? If yes, why were they undertaken and what outputs were produced? If they are still ongoing, should they be continued?

Dengue was not specified in early activity documents. The activity was a response to the epidemic in El Salvador and USAID included dengue under the amendment to the activity document and in SOAG Amendment No.9. It is too early to identify outputs. Additionally, there are seven core-funded activities in reproductive health that were not originally specified in USAID/El Salvador documents and that have been undertaken at the request of USAID Global Health. As indicated in Section 8, the reproductive health activities are many and the management burden is very considerable. In the future, USAID/W will have to understand that USAID/El Salvador PHN will only give concurrence to core-funded USAID/W activities that will have a direct and considerable impact on their SO.

4.2 Planning: Decision-making process on how to allocate inputs to undertake activities.

Has activity management developed an overall implementation plan taking into account planned inputs, the activity timeframe, and the expected outputs?

USAID/PHN and the MOH have developed an overall Action Plan for the SALSA Project, including a budget broken out by broad health sector area, and funding source (MOH and or USAID). This Plan is further defined on an annual basis with a jointly agreed-upon work plan setting forth specific objectives for the Plan year by inputs, activity timeframe and the expected outputs. The MOH and USAID agreed on indicators at the onset of SALSA. Amendment No. 9 to SO No. 519-003, August 30, 2002 redefined the indicators: the MOH is responsible for reporting on nine on a quarterly basis.[13]

How have the various parties involved, (e.g. USAID, CAs, host country partners) been included in drawing up an implementation plan and how are their priorities reconciled?

The joint annual Plan is developed in draft by the MOH using technical assistance from the USAID-financed Cooperating Agencies. The draft document undergoes a series of revisions by USAID and the MOH until priorities and budget are reconciled and a mutually agreed-upon Plan has been approved by the MOH and USAID. The annual Plan development is a time-consuming process, but because it involves key decision makers from both the MOH and USAID, and is based on program output data and revised planning by the MOH, the process is considered valuable by both parties.

Has the implementation plan been followed to date? Does it need modification for the last two years of strategy implementation?

[13] Percentage of deliveries attended by skilled personnel, percentage of DPT3 coverage of infants less than 12 months old, the number of decentralized healthcare delivery units (SIBASIs) developed, the number of people treated for sexually transmitted infections (that is, congenital syphilis), CYP (couple years of protection), phase-out plan for USAID-financed contraceptives developed and agreed upon by the Grantee and donors, percent of health facilities implementing DOTS, Directly-Observed Treatment (for TB), Short-course, number of Health Promoters trained in community Integrated Management of Childhood Illness (IMCI), and percent of family planning service delivery points stocked according to plan.

The Plan has been followed and has been modified yearly to adjust to program changes. The most significant change has been the MOH development of SIBASIs as the base for health services, and the agreement by USAID to concentrate many SALSA program efforts in seven SIBASIs. SALSA implementation appears back on track after major MOH and USAID work resulting from the earthquakes. For the last two years of SALSA, the Review Team has provided recommendations under the each component section. In most cases these recommendations confirm what SALSA is going. The Review Team does recommend, however, dropping cervical cancer

4.3 SALSA/MOH coordinating Unit Management/Administration:

Has activity implementation been helped or hampered by activity organization (i.e., lines of authority, division of responsibility, job descriptions).

The SALSA Coordinating Unit was set up specifically for this project, with overall coordination under the direction of the Vice Minister for Health. This senior level of management oversight has proved to be generally useful in that it results in the Vice Minister being actively involved in management of the MOH project at many levels. Thus, The Vice Minister has an understanding of MOH operations at a level of detail not normally found in a Health Ministry, and this is useful for overall understanding of the MOH health program.

The USAID/PHN office director has a bi-weekly meeting with the Vice Minister for Health to go over project implementation issues, using an agenda prepared and reviewed in advance by both parties, thus setting the stage for action at these review meetings. According to Review Team discussions with the Vice Minister for Health, and the USAID/PHN Office Director, the meetings have greatly enhanced SALSA program implementation and are a model for all other projects.

The SALSA Coordinating Unit itself originally had a staff of 16 people, now refined down to 11 positions, with three of the positions funded by USAID, viz: secretary, legal assessor, and chief of finance. This Coordinating Unit, under the direction of an administrator, has the responsibility to coordinate the SALSA project with both USAID/PHN technical officers, and the various technical departments of the MOH. The Coordinating Unit took at least one year to become well established.

Prior to the SALSA activity, USAID financed the APSISA Project in the health area. The Management Unit and some of the staff from the APSISA Project were carried over to the SALSA Project. Unfortunately, there were various audit findings (later resolved and closed) from the APSISA project that created strained relations within the MOH towards USAID. The audit findings on SALSA have been quite minimal and have been resolved. There continues to be a need for additional training on how to manage procurement using USG procedures. In an effort to better understand management and staffing in the SALSA Management Unit, USAID contracted with KPMG to undertake a management audit of this Unit (Coordinating Unit of SALSA management audit, Peat Marwick, May 9,2001). The Review Team was given version three of the report because the final report could not be located. Some recommendations from this report are found under the various questions below.

How well are the following administrative tasks carried out?:

Fiscal management, including tracking activity costs, financial record-keeping: The USAID audit of the SALSA Activity for 2001 was issued in final form as this report was being drafted: there were no negative findings in the report. Although the draft KPMG management audit report cited above states that “Inventory control and end-use check has been and still is a serious problem” and

went on to say that there needs to be a "…periodic update of procurement and contracting policies", the Review Team assumes that previous problems have been resolved.

- **Procurement and distribution of supplies and equipment:** Due to audit problems and the slow rate of procurement, all procurement for SALSA over $25,000 was taken over by USAID. USAID has assigned two individuals in the Contracts and Grants Office to work directly with USAID/PHN as part of the SALSA Activity team. These individuals both report that purchase problems relate to such critical areas as the quality of technical specifications provided by MOH managers and changes in specifications. Distribution of supplies and equipment is an area of concern, in part because of the amount of procurement under SALSA and slow MOH sign-off on acceptance of goods. The team does not believe that USAID/PHN should manage the contracting over $25,000 because this is a management burden for USAID/PHN technical staff who should spend their time on technical activities.[14] Could the Contracts and Grants Office play a stronger and more proactive role to lighten the contracting burden on USAID/PHN?

- **Management information system:** Initially, Booz Allen was contracted by USAID under competition to develop a health information system for the MOH. Because the Booz Allen proposal was not in line with the terms of their contract, agreement could not be reached on their proposal and the contract was terminated. The MOH does not have the technical capacity to develop a new and more useful health information system and has contracted with four individuals to work on different aspects of record keeping, a Web page for the MOH, and assistance with computerization. This technical assistance does not, however, include the development of an up-to-date information system.

CDC will be helping the MOH to improve its disease surveillance system, including strengthening disease information system. USAID notes that it is possible for CDC to design a streamlined disease information system that could be broadened to include service statistics and perhaps other types of information, but the timeline is extremely tight.

- **Intra-activity communication:** The initial year of SALSA project implementation was difficult. However, with the bi-weekly meetings of the USAID/PHN director and the Vice Minister for Health, there has been marked improvement in project implementation. The Vice Minister states that in preparation for these meetings, he meets at least bi-weekly with the SALSA Coordinating Unit administrative director and the lawyer from this unit to review problems and progress. In addition, the USAID/PHN director has internal weekly meetings to review project implementation and problems. Added to this are monthly meetings between the administrative director of the SALSA Coordinating Unit and the USAID/PHN technical staff assigned to manage each major technical area of SALSA where progress is reviewed. The one weakness in the SALSA management system appears to be a lack of coordination between the SALSA Coordinating Unit and the managers of the various health areas within the MOH. The USAID Contract and Grants Officer personnel believe this is due to the fact that the administrator of the Coordinating Unit has no authority over managers of the various technical divisions within the MOH.

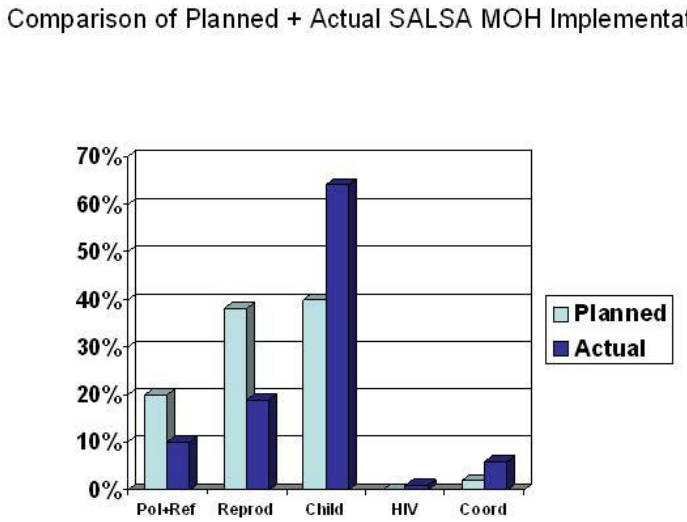
Recommendation:
Monthly meetings between the SALSA Coordinating Unit Administrative Director and USAID/PHN could include the addition of other key Unit staff to broaden the understanding and management of the SALSA project. To broaden communication, at least once every two months the joint meeting between the USAID/PHN director and the Vice Minister might include the MOH "gerentes" involved

[14] USAID indicates that the USAID Contracts Office has made a concerted effort to train the SALSA Coordinating Unit staff in USG purchasing procedures over several years and this training does not seem to have effected positive change.

with the program. Projects in other countries have also funded periodic workshop meetings to go over implementation plans and further strengthen the desire to move the Activity forward.

What proportion of the costs of the activity is for management/administration in comparison to the operational aspects of the activity, such as provision of TA, commodities, services?

Amendment No. 9, signed in 2002, increased the USAID contribution from $37,450,000 to $58,596,910, the Grantee contribution from $12,550,000 to $18,299,000, and extended the SO period two years to end on September 30, 2004 and the activity completion date to June 30, 2005. It is not possible for the Review Team to break-out the personnel costs for management/administration, because the USAID/PHN technical component managers and the MOH technical component managers and staff at every level of the MOH health system play an important role in the administration of the project. Of the total amount for SALSA, only a very small percentage goes to pay for the SALSA Coordinating Unit; on the order of $250,000 per year, including the three individuals financed by USAID, and the rent of the offices (now paid by USAID to rent a house/office since the earthquake in 2001 damaged the MOH offices for the Unit). This Figure, however, presents the planned and actual SALSA implementation by component.



4.4 SALSA/MOH Coordinating Unit Staffing:

Are the levels of staffing adequate for current activity needs?

The Annual SALSA Plan for the period June 2001/September 2002, unnumbered Annex titled "Componente Unidad Coordinadora," and Annex 2 provide very complete information on Coordinating Unit positions by name and title. In contrast, the Annual SALSA Plan for October 2002/September 2003, page 364 says that information on the Coordinating Unit relates directly to MOH management, administration and finance and is internal to the MOH. Page 381 of this same Plan does provide an organogram of the Coordinating Unit. The difference in the level of detail from one Plan year to another makes comparison a bit difficult; but, inasmuch as the MOH funds all the positions but three, and bears the brunt of the audit findings, one would think the MOH would know what level of staffing was needed.

The KPMG management audit cited above states, presumably after an in-depth review of the Coordinating Unit, that SALSA management "…has sufficient administrative and technical personnel." It is difficult for the Review Team to make a comparison on staffing due to the limits outlined in para one above; however, it is noteworthy that the staffing of the Coordinating Unit was reduced from 16 to 11, with three of the positions financed by USAID. This reduction must have been based on some findings not available to this Review Team. Other than for the areas of contracting (using USG funds), and oversight of the distribution of commodities, it appears from the KPMG audit that the Coordinating Unit is adequately staffed. However, there is some question within USAID/PHN about the continuing need for the lawyer that is presently financed by USAID. There has been the suggestion by USAID/PHN that funding for the present lawyer be terminated and USAID fund a lawyer, well versed in government personnel regulations and relationships with the Ministry of the Hacienda (the ministry responsible for GOES personnel positions and salary levels), who might be assigned to the Health Reform component of the reform process.

Recommendation:
USAID/PHN and MOH/SALSA should review staffing requirements and adjust as needed, with particular attention being paid to the legal framework and staffing required for SIBASI program management and implementation.

Are staff qualified for their tasks (education and experience)?

The Review Team did not have time to evaluate staff qualifications. There is agreement on the importance of the Coordinating Unit's administrative director having strong management and coordinating abilities.

Is staff spending appropriate amounts of time on respective activities to enable achievement of results?

The only measurements the Review Team has is information from USAID and the MOH health staff and the KPMG audit report. As noted above, KPMG believes that the Coordinating Unit has sufficient administrative and technical personnel. For this Review, it appears that after a difficult beginning, the Coordinating Unit functions fairly well. The important qualifier is that the Administrative Manager (sometimes called SALSA Project Manager) may need to involve her senior planning and administrative officers in the monthly coordinating meetings with USAID/PHN to ensure broader coordination.

4.5 Performance Monitoring:

Based on the perspective gained during the present exercise, assess the accuracy and completeness of the information derived from the monitoring and evaluation activities. How can this process be improved upon over the last two years of implementation?

In the time of this review, the Review Team couldn't assess the accuracy and completeness of the information provided to USAID/PHN by either the MOH and the USAID-financed CAs. However, individual members of the team reviewed samples of the monitoring and evaluation documents. In general, there is an extraordinary amount of high quality information that is compiled on the project. On October 15, 2002, while the Review Team was undertaking this Review, USAID received the first quarterly report from the MOH with data on each of the nine indicators that were agreed upon in

Amendment No.9. It was an important step forward. The report is simple, clear and conveys key data that both USAID and MOH will want to monitor, quarterly, to ensure SALSA is on track.[15]

While the first line of responsibility with USAID/PHN for SALSA/MOH performance monitoring lies with the CTO and activity managers assigned to this activity, within USAID/PHN the deputy director of the office has the task of compiling and monitoring all health portfolio data. It is extremely useful for one individual in PHN to have oversight for monitoring and evaluation, as this centralizes the flow of information and allows for analysis and corrections as needed.

The nine indicators that the MOH is currently reporting on seem essential for program management. Review Team members note, however, that there is no indicator for dengue and that perhaps the indicators in water and sanitation do not reflect the combination of hygiene behaviors needed to achieve a sustainable impact on health outcomes. The team suggests that if there is to be an extension of the dengue project, USAID consider including a dengue indicator. In the next strategy, USAID might reconsider the water and sanitation indicators; note that this would affect data collection by the contractor, not by the MOH.

How has performance monitoring been used as a management tool? How can this be improved over the last two years of implementation?

The annual Plan development process has adequately made use of performance monitoring; it has allowed for strengthening of several main Activity components, including the provision of more CA technical assistance. Certainly, a quarterly review of the status of the key indicators, as recently presented in October, will be a key management tool for both USAID and the MOH. With the MOH assignment of seven focus SIBASIs to USAID, the MOH and USAID will want to consider which of the indicators should be tracked on a SIBASI level, as well as on a national level.

4.6 Coordination with Other Agencies and the Government

At what stage in the assistance process (needs assessment, program/activity formulation, activity implementation, monitoring and evaluation) and at what level (USAID other donors, government, and cooperating agencies, contractors/grantees) has coordination taken place?

SALSA is a complex project. Its policy and reform component requires close high-level attention within USAID and on the part of the MOH , the SIBASIs and the contractors, both to ensure that all are working together with a shared vision and common strategy, and also to enable the project to fine tune its approach in accordance with the policy environment. One approach USAID might consider to strengthen coordination would be to request all the policy and reform actors to prepare a joint annual work plan and to present joint reports. By preparing these together, partners would gain a better understanding of one another's activities. This would lessen the management burden on USAID and free up USAID staff to devote more time to monitoring the overall environment for health policy and reform, identifying new opportunities and observing implementation first-hand.

Besides the need for effective coordination among all the actors in one specific program area, these actors also need to develop a shared vision of SALSA with the partners in all the other components. The co-location of all the SALSA CAs in the same building does not appear to fully address this need as SALSA coordination unit representatives in the MOH perceive that the SALSA CAs operate as

[15] Additionally USAID and the MOH employ FESAL indicators, data on which is collected every five years: maternal mortality ratio, infant mortality rate, child mortality rate and the total fertility rate.

independent agents, each with its own agenda. Further exploration with the SALSA coordination unit and CA representatives might suggest new approaches to address this.

On a macro-level, USAID/PHN plays a strong coordinating role in the CIM-R (Committee Interagencial para la Modernization y la Reforma). For health assistance, the primary donor partners for coordination are USAID, PAHO, GTZ, and the IDB. The leadership of CIM-R rotates, but USAID/PHN more often than not convokes the meeting. USAID/PHN has noted a diminishing donor enthusiasm for support for health programs in El Salvador since 1998. While this committee is important, bilateral and institutional coordination plays an even stronger role. As the major donor in the health field, USAID has a unique role to play to ensure coordination, not only at the project design stage, but during implementation. The Review Team gives very high marks to USAID/PHN for the importance that is given to coordination, and the various mechanisms that have been set up to ensure this coordination at all levels as outlined above.

Members of the CIM-R mechanism that brings together the donor agencies supporting health policy and reform all consider it an effective tool for coordination. However, they identify a need for the MOH to develop a more effective role in donor coordination. Several noted that the MOH's director of external cooperation, who left last year, has yet to be replaced and that the MOH has assigned this role to someone else only on an interim basis. Perhaps in its technical assistance to the MOH on internal restructuring, SALSA could include a review of how other MOH s in the region handle the external cooperation function and the respective merits of different approaches.

Has a lack of coordination caused problems in activity implementation, e.g., duplication of effort of different donors or conflicting activities? How can coordination be improved?

Lack of coordination does not appear to have caused problems with duplication of effort or conflicting activities; there appears to be coordination. For example, both GTZ and PAHO were involved with the test program for SIBASI. With the nationwide SIBASI program and the linking of various SIBASIs with individual donors, duplication of effort at the field level should be minimized. With the Vice Minister for Health chairing the SALSA management committee and similar management mechanisms with other donors, the possibility of duplication is reduced.

4.7 Relationship with USAID/W

How do activities in the portfolio relate to USAID Global Health, LAC and other USAID Missions in Central America and by what means do these unites relay their views to the activity management. If there have been problems in the activity due to the GOES/USAID or CA/USAID relationship, what have been their causes?

Activities in the portfolio take advantage of the technical expertise that USAID/W is able to offer. CA technical assistance has been integrated into the MOH program; with the possible exception of adolescent health, MOH program managers indicated that they believe that the USAID-provided technical assistance is extremely well coordinated and responds to their program needs as outlined in the SALSA Annual Plan. Moreover, each of the USAID/PHN technical program managers has stated that the CA technical advisors are first-rate, and work as a team with the MOH.

The use of Field Support funds has greatly helped to increase the USAID/W knowledge of and support for the USAID health assistance effort in El Salvador. Specifically, in the area of health policy and reform, the Mission initially worked with the support of the LAC Bureau's Regional Health Systems reform Initiative. Continued coordination on the issues of social insurance and decentralization would be useful, as would participation in upcoming study tours.

With regard to Environmental Health, there is a close relationship between both the Water and Sanitation and the Water and Environment Programs. The environmental Health Project (EHP) conducted the mid-term review (2000) of the PROSAGUAS project and also participated in an initiative to explore potential models for an ongoing technical assistance mechanism for water committees (March 2002). Regarding dengue, the CHANGE program works with Global Health on latest support initiative. The relationships with BASICS, PRIME, and DELIVER projects are close and there is continuing contact either through the individual technical advisor working with the MOH, or directly from the USAID/PHN technical advisor to the headquarters office (with copies to the USAID/W CA manager and the local advisor). FHI, CDC and CHANGE are HIV field support partners. Finally, while the HIV/AIDS assistance has greatly expanded in FY2002, the coordination with central projects is positive and very supportive.

The Mission reports, however, there were problems with a core-funded project setting up activities in El Salvador with insufficient consultation (and concurrence) of the Mission. Mission, CTO and partner staff are working to improve communication.

Recommendations:

As Table 1 indicated, USAID/PHN staff are managing relationships and activities with a great many institutions. Only USAID/PHN El Salvador can decide if additional field support or core-funded projects are useful and can be managed. Any new USAID/W activity should have direct and considerable impact upon USAID/El Salvador PHN achieving its SO.

5. POLICY AND REFORM

5.1 The Problem

How to organize, provide and finance sustainable health care services?

5.2 Partners

USAID has implemented the policy and reform component of SALSA with several partners. In the GOES, the main partners have been the MOH at the central level and recently the SIBASIs of Suchitoto, Cojutepeque, San Vicente, San Miguel, La Paz, Jiquilisco and Usulutan. The MOH began work on policy and reform under SALSA in 1999 and has spent $746,000 through September 2002. The seven SIBASIs are preparing their first annual plans for the SALSA project to begin in FY03. In addition, SALSA provided technical assistance to the National Assembly and the ISSS through 2000. This report does not review technical assistance to the ISSS since the Mission SO focuses on improving the health of the rural poor and USAID/El Salvador does not plan to carry out future work with the ISSS under this SO.

The three cooperating agencies that have provided policy and reform technical assistance under SALSA are Management Sciences for Health (MSH), which provided $1.727 million in technical assistance from May 1999 through December 2001. Booz Allen and Hamilton provided $950,000 in technical assistance from January 2000 through September 2001. The Partners for Health Reform Plus (PHRplus) has provided technical assistance under SALSA since November 2001 and has executed $543,000 through September 2002. (Annex D1 provides a comprehensive summary of each of these agreements)

5.3 Evolution of Policy and Reform in the SALSA Strategic Framework

When SALSA was designed in 1998, the SO was "Sustainable improvements in health of women and children achieved" and the policy and reform intermediate result was "Enhanced policy environment to support sustainability of child survival and reproductive health programs." The project proposed to track achievement of this result by monitoring: (a) the percent of MOH expenditures that were allocated to primary care; (b) the percent of expenses recovered by the MOH from fees charged to users at the health facilities; and (c) policies and budget allocations that favor PHC and place greater emphasis on needs of vulnerable women and children.

The project aimed to increase each of these. This was consistent with key elements of the SO. Increased MOH spending on PHC, and policies and budget allocations favoring PHC, would indicate a greater emphasis on health measures that could benefit women and children. Increased cost recovery would indicate greater possibility that improvements could be sustained over time. SALSA was to bring about these changes by focusing on interventions that would improve cost-recovery and cost-sharing, modernize health structures and systems and lead to more effective coordination of policies, plans and resources in the health sector. Specific policy and reform interventions were to include:

1. Development of legislative and regulatory framework with policies and budgetary priorities favorable to improved MCH care;
2. Reform and modernization of the health care delivery system. Support for new and efficient models for delivery of health services;
3. Policy research to support reform and modernization of the health system and of health service delivery;
4. Coordination among key health sector decision makers and among donor agencies to enhance effective use of health resources.

In September 2001, when USAID prepared Amendment 6 to the SOAG, the policy and reform component was modified slightly. The indicator of "Percent of MOH expenditures allocated to primary care" was dropped due to lack of data. Since by this time, the MOH's decentralization had advanced beyond what was anticipated at the design stage to include SIBASIs, the project then added a new indicator for policy and reform, "the number of SIBASIs developed by the MOH". This change also demonstrates that SALSA's approach to policy and reform evolved to include increasing attention to helping the MOH to carry out institutional decentralization.

The August 2002 Amendment 9 to the SALSA SOAG reflects a more substantial shift in the project design with respect to policy and reform. First, the SO is modified to remove the emphasis on sustainability and to add adolescents as an additional target group. The SO framework no longer includes any intermediate result directly in the area of policy and reform. Rather, it includes two new sub-IRs on policies—one to strengthen policies for service access and another to strengthen use of services and practices. The single policy and reform indicator that is retained is the number of SIBASIs developed by the MOH. The cost recovery indicator was likely dropped in response to the MOH decision in June 2002 to make all health services at the primary level (the unidad de salud) free of charge.

These changes suggest that SALSA's current development hypothesis is that the policies to strengthen access and to improve use and health practices can best be accomplished through the development of SIBASIs by the MOH. At the level of policy interventions, SALSA shifts away from the health system more broadly toward a narrower focus on the institution of the MOH and shifts away from legislative interventions to those focused on the executive branch. A new emphasis emerges on the role of municipalities and donor coordination takes on a more central role. (See annex D2 for a complete review of these changes.)

In part, this evolution reflects the growing level of definition of health policy since SALSA was designed. The MOH has decided to deconcentrate institutionally to the local level through the creation of SIBASIs and SALSA is providing support for this deconcentration. On the other hand, the project should not abandon its broader focus on critical health reform and policy issues beyond the development of SIBASIs, such as the financial sustainability of the health system, its ability to collect adequate revenues and target social spending to the underserved, steps toward universal health coverage, and the integration of the disparate parts of the health system—including the MOH , the ISSS, private for profit providers and insurers and NGOs. Keeping a broad focus is particularly important in the area of reform and policy, where the environment is so difficult to predict and where critical opportunities for change can emerge unexpectedly.

5.4 Policy and Reform Activities

USAID technical assistance in policy and reform has been of uneven intensity over the life of the project. BASICS I provided early technical assistance (TA); the APSISA project also provided TA. MSH began in May 1999. From 5/99 to 12/00, MSH provided about $54,000 per month in technical assistance (albeit some to the ISSS). Then, with the arrival of Booz Allen, support for health reform and policy rose to about $100,000 per month through 9/01. With the 12/01 departure of MSH and the 11/01 arrival of PHRplus, monthly technical assistance for policy and reform dropped back to about $50,000 per month.

Just as the strategic framework for policy and reform has evolved over time, so has the emphasis of policy and reform activities. SALSA tasked MSH with three key roles:
(a) assisting the MOH to develop and implement decentralized units (SISAs at that time),
(b) providing the National Assembly public health committee with technical assistance to strengthen its capacity for legislative oversight of the health sector and to draft and promulgate appropriate legislation for health reform; and
(c) providing technical assistance to the National Health Commission for high-level, inter-institutional oversight and direction to national health reform process.

MSH provided substantial assistance to the MOH and helped the Ministry develop the groundwork for the restructuring of the central Ministry as well as the establishment of the decentralized SIBASIs. Working together with the central MOH , MSH developed and disseminated the basic documents for stewardship, strategic planning, internal regulation and the four new directorates—quality assurance, regulation, administration and financing, and planning. MSH also developed the SIBASI manual.

In addition to these planned roles, MSH took on the additional tasks of providing technical assistance to various groups to develop alternative proposals for health reform and helping to identify the common elements of these proposals, as well as providing technical assistance to the ISSS. The provision of technical assistance to a broad array of parties on health reform helped USAID and SALSA establish their position as an impartial and honest broker in this field. This has gained respect for USAID within the health sector reform community in El Salvador and has been cited as a unique and valuable approach by observers elsewhere. In retrospect, it is less clear why MSH provided support to the ISSS since this held little potential to contribute to SALSA's SO of improving the health of the rural poor.

SALSA incorporated the services of Booz Allen and Hamilton in January 2000 to provide technical assistance to the MOH in information systems. The MOH had two clear goals:
(a) to develop an executive health information system (EHIS) for the MOH and its decentralized units (SISAs at that time) that would include decentralized information needs as well as population, epidemiological, facility and a Statistics and Epidemiology Integrated System (SIEES); and
(b) to develop a national health information system (NHIS) that would integrate health information from all sources (inside and outside of the MOH).

Booz Allen developed a proposal with options for information solutions, but it did not meet the MOH 's goals. First, Booz Allen proposed delegating the MOH epidemiological information system to CDC. They decided not to integrate the executive health information system because they determined the existing systems to be out-of-date and of poor quality. They determined that it was not feasible to develop a national health information system. They further proposed more limited dissemination and training than the MOH requested. The Ministry found Booz Allen's technical assistance unsatisfactory and the SALSA project terminated it.

The SALSA project brought in the Partners for Health Reform Plus (PHRplus) project in late 2001 to work on three areas—policy, finance and decentralization. In the area of policy, the activities that PHRplus plans to carry out are:

- political mapping ;
- developing an advocacy strategy for the normative process;
- developing indicators for SIBASIs and helping the MOH to apply them;
- helping the MOH to program how to use USAID funds to support health system strengthening; and
- supporting the MOH in promoting the rapid adoption of SIBASI best practices

In finance, PHRplus will work to:

- improve the normative environment to support a modernized MOH at the central and zonal levels and efficient SIBASIs at the local level;
- carry out an equity analysis of NHA and survey data;
- organize a seminar series on health financing;
- provide advocacy support to local and zonal level for best practice implementation at all levels; and
- develop operational directives for the SIBASI model.

In decentralization, PHRplus will:

- strengthen SIBASI capacity to deliver integrated basic services to vulnerable populations;
- disseminate best practices;
- develop communication strategies; and
- introduce financial management, governance, information and human resource management systems for SIBASIs

So far, PHRplus has carried out a baseline survey of SALSA's seven SIBASIs, helped SIBASI teams to develop their first year SALSA action plans, developed a more comprehensive composite indicator of a "well-functioning" SIBASI for standardized monitoring and evaluation system, and facilitated a donor meeting of CIM-R (USAID, IDB, GTZ, PAHO).

5.5 Policy and Reform Results

5.5.1 Indicators of achievement of objectives

Over the life of the project, SALSA has had three indicators to track its achievement in the policy and reform area.

(a) Percent of Ministry of Health expenditures allocated to primary care (8/98 to 8/01)[16],[17]

[16] As noted previously, since the MOH has carried out National Health Accounting exercises from 1996 through 2001, it should be possible with further analysis of available data to determine the share of MOH spending on primary care, but it is not readily available.

(b) Percent of expenses recovered by the Ministry of Health from fees charged to users at the health facilities (8/98 to 8/01)
(c) Number of SIBASIs developed by the Ministry of Health (9/01 to present)

The project does not appear to have tracked either of the first two indicators, due to lack of data[18]. For the third indicator, the MOH developed five criteria to determine the stage of development of a SIBASI. These criteria are that:

1. the SIBASI has financial resources available to permit timely purchases of medicines, supplies, etc.
2. the SIBASI has agreed to provide services through management agreement.
3. the SIBASI has complete technical and administrative structure with minimum, appropriate resources to function.
4. the SIBASI has formalized the Management Committee and the Social Consultative Committee
5. the SIBASI has norms, protocols, and organizational and functional manuals.

The PHRplus helped the MOH to assess each of these criteria for the seven USAID SIBASIs to establish baseline measures for tracking progress.

TABLE 2: Progress of SIBASIs according to MOH criteria developed 8/01 Period 10/01 – 9/02

SIBASI	1	2	3	4	5	Total	%
Cojutepeque	1	1	2	2	2	8	80
Suchitoto	1	1	2	2	2	8	80
La Paz	1	1	2	2	2	8	80
San Vicente	1	1	2	2	2	8	80
Jiquilisco	1	1	2	2	2	8	80
Usulatan	1	1	2	2	2	8	80
San Miguel	1	1	2	1	2	7	70
Total	7	7	14	13	14	55	78.57
Average	1	1	2	1.9	2	7.9	
Percent progress by criterion	50	50	100	93	100	78.57	

In addition, PHRplus is working with the MOH and SIBASIs to develop a more in-depth matrix that would track eleven functions that the SIBASI is supposed to be able to carry out.

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[17] While information is not available on the percent of MOH spending allocated to primary care, we can observe trends in MOH spending as a share of Gross Domestic Product (GDP) over time. A review of MOH spending from 1997 through 2001 as a share of GDP shows no clear upward trend. In light of the static pattern in MOH spending that indicates no increased government priority for MOH spending on health, it is unlikely that the MOH devoted an increasing share of its resources to primary care over that period since this would have required reallocation away from other uses, such as tertiary care, and shifts away from tertiary care do not appear to have taken place. It is possible that absolute increases in health spending in 2000 might have been directed to primary care.

Trends in MOH Spending as share of Gross Domestic Product (in colones)				
	1997	**1998**	**1999**	**2000**
MOH spending	1,750,267,799	2,025,361,699	1,934,894,258	2,241,690,483
GDP	97,428,625,000	105,073,500,000	109,115,125,000	115,610,250,000
Share	**1.80%**	**1.93%**	**1.77%**	**1.94%**
Source: NHA 1996-2001				

[18] The first indicator was measured early in the project; it was then deleted due to lack of data.

5.5.2 Other Evidence of Results

One of the unique challenges of reporting on the results of work in policy and reform is the particularly long lag time between activity implementation and impact and the non-linear path of change. Sometimes, policy and reform activities produce impacts long after their culmination. Others produce results beyond what was expected during implementation.

USAID's PROSAMI NGO contracting model has broad impact: the PROSAMI project provides a good illustration of this. Years after its 1990 to 1998 implementation, the early work that USAID sponsored through the PROSAMI project and incorporated into the SALSA transition plan has the potential to impact the rural poor well beyond those served by the initial project. Using the PROSAMI experience, the MOH is in the process of contracting out to third parties for the delivery of health services to about 100,000 rural poor people. The IDB is adapting the PROSAMI model in its current $20.7 million health loan (for contracting health services for 200,000 to 250,000 rural poor) and the World Bank has included this model in its $167 million health loan (for contracting health services for 350,000 rural poor people in municipalities in Cabanas, Chalatenango, La Union, Morazan, San Miguel and Santa Ana).

USAID-supported ANSAL provides the analytical basis for national health reform: together with PAHO, the IDB and the World Bank, USAID supported the ANSAL (Analisis del Sector Salud de El Salvador) in 1994. This work provided a comprehensive picture of El Salvador's health system and its deficits. It contributed to a consensus about the need for reform of the health sector and continues to provide much of the analytical basis for current reform proposals.

USAID is an honest broker in health reform

USAID's approach in support of health reform in El Salvador has been that of an independent source of technical assistance not trying to sell any particular agenda. This has been true from its early collaboration in the funding of the ANSAL health sector assessments in 1994 to the support for various groups proposing health reform alternatives in 2000. This has gained respect for USAID within the health sector reform community in El Salvador and has been cited as a unique and valuable approach by observers elsewhere. This approach allows USAID to modify its support as the country continues to refine its vision for the health sector. The challenge inherent in this approach is how to provide critical feedback on reform proposals that emerge. For example, how can USAID help El Salvador work on the SIBASI model while urging the GOES to consider and address possible drawbacks of this model.

SALSA technical assistance enabled the MOH to carry out a major restructuring in which the Ministry reorganized to assume the stewardship functions of regulation, quality assurance, planning, and finance and administration. Because SALSA provided this technical assistance in a collegial way, MOH representatives took ownership of the products and processes they participated in developing. They comment that SALSA worked in partnership *with* them rather than developing new systems and procedures *for* them.

Likewise, SALSA technical assistance has enabled the MOH to create decentralized SIBASIs, to define their roles and responsibilities, and to prepare local health staff to assume these new roles. SALSA is currently working with the MOH to define the management agreements that will serve as the basis for the Ministry of Finance's 2003 budget transfers to these SIBASIs.

SALSA helped El Salvador craft a consolidated vision for health reform from a variety of proposals. By providing technical assistance to a variety of different actors in the health reform process, SALSA promoted broad, transparent participation in shaping the vision of the health sector and enabled El

Salvador to benefit from open consideration of the widest possible array of alternatives. SALSA also helped the GOES to consolidate these various proposals into one consensus document of principles that should guide reform.

MOH compensates for lack of results from information systems technical assistance. The lack of satisfactory results from the information systems technical assistance is problematic because the World Bank health loan was designed to use the outputs from this work as the basis for the Bank's investment in strengthening information systems. The MOH has been able to compensate for the lack of expected results from this work. They have been able to use USAID's support for CDC to help them manage disease surveillance information and PAHO has provided them with help to transfer their current hospital software to a more powerful platform for wider application

5.6 Future Directions to Consider

As SALSA moves forward and the Mission considers future support for policy and health reform, the following additional areas might be worth including.

1. FESAL equity study: Since El Salvador's health system is characterized by major differences in access, use and health status between urban and rural residents and between the poor and non-poor, the upcoming FESAL appears to provide an ideal opportunity to explore equity issues in a quantitative manner. USAID is considering funding an analysis of FESAL findings by income quintiles (disaggregated if possible between urban and rural) if it is possible to construct an asset index or another proxy of income levels from the questionnaire. This seems to be an excellent idea. It would complement the information available from national health accounts, health service statistics and other poverty studies and provide a concrete picture of the access, use and health status of USAID's target population--rural poor women, adolescents and children.

2. Using National Health Accounts: It is very heartening to see that the GOES has truly institutionalized the practice of carrying out annual national health accounts. They have published the accounts for 1998 and are preparing annual reports for 1999 and 2000 and a consolidated report for 1996-2001 for publication. The MOH planning directorate probably still could benefit from USAID technical assistance on several fronts. First, they may need help taking their work from calculations to publication more rapidly. Second, their 1998 report, because it does not provide any comparisons either to earlier years or to trends in other countries, is not as useful for policy making as it otherwise could be. They may need help putting the information they gather into context. Third, they may need help to recognize how the information they have gathered can be further analyzed and presented to policymakers in order to influence decision making.

3. SIBASI accountability to the community: One of the prime motivations for the creation of the SIBASIs is to bring the health system closer to the community it serves. The model calls for the establishment of Community Consultative Committees at the level of the whole SIBASI and for each network and major facility. Yet more can be done to ensure that communities can hold SIBASIs accountable (and not simply coordinate with them. The project can draw on other precedents for lessons on how to make social services accountable to community groups. One of the most immediate is the example of the EDUCO system in El Salvador for primary education, where Parent Associations actually oversee local schools financially. In the health sector, Peru provides an interesting illustration of increasing health system accountability to the community by transferring public resources and authority for hiring and firing personnel to community organizations under the CLAS program.[19]

[19] Information on this program is available from UNICEF evaluations and other documentation by Laura Altobelli.

4. Legal foundations for reform: Several information sources have noted that when El Salvador set about finding consensus on health reform from among the disparate proposals, the only two issues they did not reach agreement on were financing and the legal framework! This highlights the tremendous challenges inherent in bringing about changes in these areas. The MOH and the GOES are seriously committed to establishing the legal framework for the modernization of the MOH and the creation of the SIBASIs. The current administration recognizes that they need to do this before they leave office to solidify the changes they have worked so hard to bring about. They have taken several steps to create the legal foundations and have plans and a timeline for achieving remaining steps during this administration. Changes so far have used existing legislation or Presidential decrees.

   In the short term, the GOES created the SIBASIs through an Executive Decree that provides them with legitimacy through 2004. PAHO carried out a legal analysis in 1999 that concluded that the MOH could use the legal basis for the health regions to create the SIBASIs since that legislation did not define the region in any way that would exclude a SIBASI. The next step is to introduce a new Health Code for approval by the National Assembly. PAHO's legal advisor is currently providing technical assistance to the MOH Regulation Directorate to draft the new Health Code. The GOES calculates that the window of opportunity for introducing the new Health Code is between March and November 2003. The internal regulations of the MOH have reached the Secretary of the Presidency and they need to be submitted to the National Assembly for approval, most likely during that same window of opportunity.

5. Health care financing (and catastrophic care): Through its support for SALSA, USAID is seeking to ensure that poor rural underserved Salvadorans have better access to and use of health services and practices. This can only happen by devoting increased resources to reach the underserved. The extra financial resources can only come from a few sources—increased government revenues for health, shifts of government health spending away from other users and/or services, increased contributions by businesses, increased donor contributions, efficiency gains from better management of the health sector, and increased payments for health services.

   Further work is needed to develop viable options for sustainable financing for health care for the rural poor, as none of them presents an easy solution. El Salvador's ability to collect taxes is weak. While the economy is growing, major increases in government revenues are not likely in the short term. The political environment is not conducive to introducing shifts away from other users and/or services for the non-poor in order to attend to the rural poor. Increased donor contributions are not sustainable over time. It is not clear what would motivate increased business contributions. The GOES has just introduced a policy canceling user fees at the primary level and the political environment in the short run does not lend itself to increasing other user charges for health services. Efficiency gains may be possible if service use patterns shift from hospital care to service delivery through health units. With improvements in service coverage and quality, it might be possible to convince users to pay for services. Community social insurance schemes might be one option worth exploring. The SIBASI model as currently envisioned does not tackle the difficult issue of how to sustainably finance health care for the rural poor. It must address this issue in order to succeed.

6. Targeting public spending on health: The GOES first year transfer to each of the SIBASIs will use historical levels as the basis for resource allocation. Part of the aim of creating the SIBASIs is to redress the inequalities inherent in resource distribution. In order to do this, the GOES will need to develop resource allocation mechanisms that incorporate indices of need. They will need technical assistance to do this. A number of initiatives to assess poverty in El Salvador can serve as inputs. These include the work done by UNDP on unmet basic needs, the World Food Programme work, the analysis the World Bank recently carried out to target its health project funds, and the poverty work

that USAID has carried out. Experiences of other countries, such as Chile, with resource allocation formulas for decentralized management of health, also can serve as inputs.

7. Effective strategic communications in health: This portfolio review takes place in the context of a strike by ISSS personnel to protest against changes in the social security system. The ISSS serves less than 17% of the population and none of the rural poor. Client satisfaction with ISSS services is lower than in the less well-funded MOH. Yet this protest has dominated the media and disrupted transportation in the capital and throughout the country over several weeks. In the media coverage of the protests, the voice of the rural poor is silent. The efforts of the MOH to take care closer to those in need go unmentioned. The MOH needs support for improving its strategic communications about its priorities, accomplishments and aims. The IDB is taking an active role to assist the MOH with this and SALSA TA could partner with them. In addition to ideas the IDB already has, an additional strategy worth exploring is work to educate the press to cover health from a well-informed and comprehensive perspective.

8. Health system integration: While the MOH goes ahead with its institutional deconcentration to the SIBASIs, El Salvador continues to plan how to reform its social security health system. These two initiatives need to be integrated so that El Salvador does not end a long process of health reform to find itself with two fragmented and disarticulated sub-systems, each serving different population groups. While decision makers are aware of this, the SALSA project can help maintain focus on the need for integrating the whole health system.

9. Fostering horizontal interaction among SIBASIs: When Ministries of Health decentralize, they tend to continue to manage their interaction with the decentralized units in a vertical manner, where the MOH is the hub and each decentralized unit a spoke. Yet the dissemination of best practices works better when the decentralized units (e.g. the SIBASIs) have their own horizontal mechanisms for exchanging experiences and lessons that operate independently of the central MOH. The SALSA project might establish a regular venue for SIBASI leaders to meet (for all the SIBASIs rather than just the 7 with USAID TA). This would provide an opportunity for "South-South" technical assistance at the local level. One possibility would be to get the CIM-R to sponsor such a venue.

10. Providing incentives for experimentation and excellence: USAID is understandably reticent to transfer project resources to SIBASIs to manage at this early stage of their development and given problems with similar transfers in the past. Yet the SIBASIs will learn to manage resources by doing so. And their first year budget transfers do not provide them with any flexibility in how they use their resources. As a complementary step to organizing a venue for sharing best practices among SIBASIs, the SALSA project might create some incentives to fund or reward innovative experiments and to recognize excellence. The quality management award program that GTZ and PAHO run provides peer recognition and token prizes to stimulate quality improvements. This might be worth exploring for the SALSA project too.

6. ENVIRONMENTAL HEALTH

6.1 The Problem

"The USAID/El Salvador Strategy recognizes that the lack of access to water and sanitation is a major constraint to health improvements in rural areas , and that the large difference in infant and child mortality rates between urban and rural areas is closely connected to the constraint." Diarrheal disease is the second greatest cause of morbidity and mortality among infants and young children. According to the 1998 FESAL, 19.8% of all infants and children under five years old suffered from diarrhea in the two weeks preceding the survey (22% in rural areas vs. 17% in urban areas). Only 27 percent of the rural population

has adequate access to potable water, one of the lowest potable water coverage rates among Latin American countries. The limited availability of high-quality ground water resources, due to degradation of watersheds, as well as heavily contaminated surface water resources, worsen the problem of access to potable water in El Salvador[20]

6.2 Partners
CARE/PROSAGUAS, CARE/PROSPERAR, PCI/FAMSAL, MOH, municipalities and community leaders

6.3 Activities

6.3.1 Summary of Programs

Health Office (Programs funded under health strategic objective with Child Survival funds)
- **CARE/PROSAGUAS (Water and Sanitation for Health)**: $9,157,722, 1998-2002. Objective: To decrease the incidence of diarrheal diseases in children under five, through the provision of potable water, sanitation infrastructure, health education and community organizing, as well as environmental protection.
- **CARE/PROSALUD (Water and Sanitation for Health)**: $4,375,000, 2002-2005. Objective: To reduce by at least 30% the incidence of diarrheal diseases in children under five years of age in the activity areas by providing adequate access to potable water and sanitation systems, as well as intensive health education interventions in rural communities.
- **CARE/PROSPERAR**: Earthquake reconstruction programs that provide water, hygiene and sanitation in conjunction with housing in earthquake affected areas. (Sept 2001 – Sept 2003) $4 million.
- **PCI/IFAMSAL:** Familias Sanas/Aguas Limpias: Water, hygiene and sanitation interventions in conjunction with housing reconstruction post-earthquake. (Sept 2001 – Sept 2003) $3 million

Water and Environment Office (funded under Water and Environment Strategic objective)- no health objective
- **AGUA (Access, Management and Rational Use of Water) 1998-2002.** Objective**:** Increased access by rural households to clean water through improved quality of water sources, improved performance of water delivery systems, more effective citizen actions to address water issues, improved municipal management of water resources.

6.4 Achievement of objectives under PROSAGUAS
(as of August 28, 2002)

- *" Activity sites with at least a 26% reduction in diarrhea among children under 5 years old.":* Based on reporting from CARE, this indicator had been monitored in 12 project sites. The results showed that nine out of the twelve activity sites achieved more than a 26% reduction in diarrhea cases among children under 5 years old (reductions ranged from 29% to 82%). Two achieved a 7 and 12% reduction, respectively; the third community which did not achieve any improvement in reduction of diarrhea cases reported, was a pilot project and did not receive either the sanitation infrastructure or the health education activities.

  An investigation on the cause of diarrheal disease in these communities is being carried out by INCAP and a final report will be ready by December 15, 2002. The results of this study will guide

[20] Request for Applications for PROSALUD

project implementers on the strategies necessary to improve achievements in this area. CARE staff speculated that inefficient chlorination and inadequate handling of water by family members might be contributing to the failure of some activity sites to achieve expected results. Increased efforts to improve water purification and storage are being implemented.

- *"Number of latrines and water systems constructed or rehabilitated":* 18 systems constructed or improved
- *"Number of rural water beneficiaries"*: 47,890 beneficiaries (9,391 households (Goal = 45,000 beneficiaries)
- *"Number of rural beneficiaries of latrines"*: 27,706 people (5,640 latrines (Goal: 22,500 beneficiaries)

6.5 Performance in Special Areas of Interest

The USAID/PHN has had an active program in Water and Sanitation for Health since 1993, providing a successful model for government entities, municipalities and other donors. The program reflects an ever-improving example of a comprehensive approach that includes construction of water and sanitation infrastructure, health promotion and education, community organizing (the development and support of community water, health and environment committees) and protection of water resources. In addition to the integrated approach, the program is demand-driven, participatory, sensitive to gender and incorporates an IMCI component to reinforce health behaviors (such as breastfeeding) that complement the more specific hygiene behaviors. Based on an interview with ANDA (the National Aqueducts and Sewerage Administration), the USAID funded water and sanitation programs are some of the best in the country with regard to approach and sustainability. When reviewing reports and external evaluations generated by the USAID program over the years, it becomes apparent that the program has incorporated the lessons learned in each successive project period (1993-1998, 1998-2002, Program Descriptions for 2002-2005).

What follows is a review of program performance in the Mission's special areas of interest:

- Coordination with partners
- Sustainability
- Adequate participation by women
- Health education methodologies

6.5.1 Coordination (internal)

As noted above, the USAID office has two programs that address issues of water access. While the Water and Environment program aims to impact water resources, municipal planning and legislative infrastructure, the USAID/PHN program focuses on water as an integral component of diarrheal disease prevention. In spite of the different overall program objectives, there are several activities that are part of both programs to different degrees, such as construction of water infrastructure, development of community water committees, collaboration with and capacity building of municipalities and local NGOs, improved water quality (chlorination), water resources protection, solid waste management, wastewater management, and environmental education (e.g. on water conservation). Both programs have had cooperative agreements with different teams within CARE for the program period 1998-2002 and will continue to work with CARE counterparts during the next project period (2002-2005).

Although the original PROSAGUAS agreement contemplated cooperation and coordination with Project AGUA, the degree of communication, joint planning and implementation may have been less than originally anticipated. There has also been limited interaction between the counterparts within CARE. This may be partially attributed to the fact that the projects operate in different geographical areas and

communities, although there has been some overlap. The AGUA program sees the benefit of adding a health component to their program, but this was not contemplated in their original work plan and would require additional resources. The Health program has incorporated an environmental protection component into their programs.

6.5.2 Coordination (external)

There has been effective coordination between the water and health programs and implementing partners. In CARE PROSPERAR, the health component was implemented by a local NGO, CALMA. In the new USAID-funded water and sanitation for health program, CARE proposes to work with three NGO partners. A good example of coordination with partners in the sector has been the participation of USAID and CARE in the Water and Sanitation Network of El Salvador (RASES) that is facilitated by PCI. Both CARE and PCI have effectively disseminated the lessons learned in USAID funded projects through the Network. Implementing partners also work closely with ANDA and with the health promoter of the MOH, when he/she is available.

6.5.3 Sustainability

PROSAGUAS has successfully employed several strategies to promote sustainable access to water, hygiene and sanitation. The program facilitates the organization of a water committee in each community to oversee the construction/improvement, operation, maintenance, and administration of the potable water and sanitation systems. In most cases, these committees can manage and operate their systems after the departure of the project. To enhance the sustainability of the committee, PROSAGUAS recently implemented a policy to change only half the committee every two years, in order to maintain continuity and train new members. Where appropriate and feasible, the program engages the local municipality in the administration of the water system or obtains agreement to provide technical or financial support for construction or maintenance of the system. The ongoing involvement of the municipality in water resources management is an important resource for sustainable systems. In addition, the program aims to build a health committee and strengthen the capacity of health promoters from the MOH to provide ongoing support to this committee.

6.5.4 Adequate participation by women

There has been a lot of progress in strengthening the role of women in USAID's water and health projects. For example, CARE has achieved at least 33% participation by women during the course of their projects. Unfortunately, projects usually suffer at least a 10% decline in women's participation after the project ends.

6.5.5 Health education methodologies

Both CARE and PCI have implemented similar and very effective educational approaches. They use the SARAR approach for community organizing and action planning to resolve water and sanitation problems. Health, water and environment committees are formed and trained on how to conduct home visits, which are a key component of the behavior change strategy. CARE has an excellent collection of educational materials, including a module on IMCI. More recently, CARE has incorporated a training approach developed by GTZ (Desarrollo de Competencias Emprendadores para la Formación de Empresas - CEFE) to build the management capacity of water committees. All modules utilize a participatory/problem-solving approach and educational materials are appropriate for the level of their audience. Educational approaches in the community are complemented by school based programs.

With regard to evaluation, CARE establishes baseline behavioral indicators (see section 7.3) and conducts a survey to identify knowledge, attitudes and practices that may support or constrain behavior change interventions. These indicators are evaluated every 6 months.

6.6 Future Directions to Consider

1. Consider adjustment of program indicators in the next strategy. The results framework includes indicators for access to water, number of latrines and water systems constructed, % reduction in diarrhea, and hand washing at one critical time (after defecation). These indicators may not necessarily reflect the combination of hygiene behavior needed to achieve a sustainable impact on health outcomes. It is well documented that access to water and sanitation infrastructure does not necessarily lead to adequate use, without health education. In contrast, the behavioral indicators used by CARE under PROSAGUAS include adequate use of the latrine, disposal of paper in the latrine, % homes with no feces in the surrounding area, hand washing after defecation, before food preparation and eating and after diaper change, disposal of paper in the latrine, purification and safe water storage.

   Although too many indicators would be cumbersome for frequent monitoring, the Mission might consider adding a few of the impact indicators for the water and sanitation related Title II activities developed by the Food and Nutrition Technical Assistance Project – FANTA- (plus one on water use and storage).[21] They are as follows:
   - Percent of child caregivers and food preparers with appropriate hand washing behavior, where appropriate hand washing includes the time it was done and the technique used.
   - Percent of population using hygienic sanitation facilities, where sanitation facility is defined as an excreta disposal facility, typically a toilet or latrine; and hygienic means there are no feces on the floor and there are few flies.
   - Percent of population using appropriate water storage approaches at household level (not FANTA).

2. Increase internal coordination. During the next project cycle (2002-2005), it would be desirable to increase the communication between the two USAID projects, both within USAID and CARE, as mentioned in the Program Description for Water, Sanitation for Health Activity.

3. Move toward one comprehensive water program. In the new strategy, the Mission may want to consider moving toward an integrated, cross-sectoral approach focused in the same geographic zone, maximizing the resources and strengths of both offices.[22] In this new program, it would be important to maintain the multifaceted interventions that have been developed over more than ten years in the Water and Sanitation for Health Program that go well beyond latrine construction and health education. There are also distinct advantages to maintaining a water program as part of an overall approach to child survival (e.g. that includes other USAID and MOH objectives such as IMCI, reproductive health, HIV/AIDS, etc.). If there were interest on behalf of the Mission, USAID/W would be happy to work with USAID El Salvador in the development of a feasible combined program.

[21] See Indicator analysis in Annex E.

[22] Such a comprehensive program would combine the key program elements (not funding) of both of the water programs (in the USAID/PHN and in Water and Environment). It would take the key elements from both and create one comprehensive program that looks at water and sanitation infrastructure, hygiene behavior change, community organizing and strengthening of water and sanitation committees, water source protection and the legislative framework to enhance sustainability.

4. Increase External Coordination**.** One area of outstanding need is increased interaction among donors with regard to their objectives, plans, and geographical focus over the next period. ANDA has expressed interest in convening the donors, however, they would like to clarify their rural water strategy prior to this meeting. As a first step, ANDA has solicited inputs from all partners on their water activities and where they are located, with the hope of convening the meeting by the end of year. This may be a good opportunity for USAID, through its implementing partners, to work closely with ANDA in this inventory process, in support of a future sector-wide strategy.

5. To build sustainability, develop strategy for ongoing technical support for committees. The need to create a mechanism for ongoing support in the technical, social and health components of the program has been mentioned in the past. There was an investigation by EHP and CARE in March, 2002 that resulted in the proposal for the establishment of departmental support teams financed by beneficiaries and municipalities. Alternatively, the AGUA program has recommended a pilot program in which a strong water committee (for example Cara Sucia) would provide technical assistance to committees in their area. It would be important to continue to explore and implement one of these options over the next two years.

6. Continue to strengthen the system of local health promoters and health committees. A few larger communities with water systems have been able to hire their own health promoter to ensure the sustainability of health outcomes. This is a successful model to encourage and promote, acknowledging that due to time constraints, the role of the health promoter from the MOH may be limited. However, the program should ensure collaboration between these health promoters and MOH health promoters. It is also recommended that similar sustainable alternatives be established for smaller systems, such as joining together to hire a health promoter or creating linkages with a larger water system. While most of the water committees have been sustained, there has been the tendency for the health committees to become weaker after the project ends. One of CARE's best practices has been to allow families to count participation in the committee as part of their labor quota for access to water. Increased sustainability of the health committees is an important factor for the future.

7. Human resources development. Updating the curriculum for engineers in comprehensive and innovative approaches to water and sanitation would be a significant contribution to sustainability. The MOH has similar objectives for integrating curriculum on IMCI into the curriculum of health professionals. Recognizing the challenge of making curricular changes, they are beginning with lectures in cooperative faculties (e.g. pediatrics), moving toward influencing curriculum. This may be a feasible approach for the water and sanitation sector.

8. Employ strategic approaches for men and women. In PROSAGUAS, the project team implemented gender awareness training among both men and women. In the next project cycle, it may be worthwhile to design special strategic approaches for men and women, more specifically, to have separate meetings with women when decisions are made to ensure adequate participation. Many women tend to be quiet in mixed groups. Skill building sessions for women in the areas of accounting and finance might also increase confidence for long-term participation on the committee. Similarly, separate workshops with men may help to explore gender issues and barriers to more sustainable participation by women.

9. Focus on specific targeted behaviors. CARE has noted more positive results in changing some behaviors such as use and maintenance of the latrine, and more difficult behaviors to change, such as hand washing and safe storage (including dengue prevention message)and use of water. Over the next two years, an effort should be made to develop targeted strategies for these specific behaviors. The methodology of Trials of Improved Practices (TIPS) has been applied successfully in other USAID

projects in hygiene and nutrition. Materials from a recent project in the Dominican Republic may provide a useful model.

10. Continue collaborating on a unified educational approach for water and sanitation. Both CARE and PCI have been participating in an initiative facilitated by UNICEF, in collaboration with the MOH, to develop a unified educational methodology and materials for both water and sanitation and water resource protection. Materials are being developed through a working group that includes government agencies, PVOs and NGOs that work in water, environment and environmental health. Products will include guidelines for facilitators (e.g. NGOs) and community health committees as well as a series of posters. The CARE modules on management training for committees will also be part of the package. The materials will be ready for distribution next March and a training program for all facilitators will be held. It is recommended that all USAID cooperating agencies and NGO partners participate in this training program and strengthen their efforts to train the MOH health promoters in their areas (in addition to their own promoters and committees). According to the organizers of the initiative, NGOs often train their own promoters and neglect the important role of the MOH promoter, although USAID notes that the PROSAGUAS strategy includes the training and participation of MOH health promoters during activity implementation.

7. INFANT AND CHILD HEALTH

7.1 The Problem

The estimated population under five years of age in 1998 was 786,000 children. Fifty percent of Salvadoran infants who die before one year of age do so in their first month of life. They die from sepsis, congenital malformations and asphyxia. And often they die because the basic family unit is so poor and the knowledge of healthy behavior so lacking that the new baby may not have a chance. TABLE 3 presents Mission indicators for child health.

TABLE 3: SO Indicators for Child Health

SO Indicators	Source of Verification	Frequency	Issue	Actual 1998	Planned 2003
Infant Mortality Rate (< 1 year): proxy: % DPT3 coverage of <12 month olds	FESAL MOH	Every five years quarterly	MOH data reports coverage of <12 months with a pentavalente vaccine that includes DPT3.	IMR :35 DPT3:65	32 68
Child Mortality Rate (12 to 59 months)	FESAL	Every five years	none	8	6

IR Indicators:

- ✓ # of health promoters trained in community IMCI
- ✓ Activity sites with at least 26% reduction in diarrhea among children < 5 years old.

7.2 Partners: MOH, BASICS II, and MOST

TABLE 4: Infant/Child Health Funding

	Timeframe	Funding Level
SALSA Child Survival	1999-2002	$8,529,189
BASICS	199-2002	$1,915,000
MOST	1999-2002	$200,000
Micronutrients	2001-2002	$200,000

7.3 Activities

The MOH and its partners have worked in six program areas to promote child health:

- Growth promotion through community-based monthly monitoring of adequate weight gain and counseling (children under the age of two years)
- Promotion of exclusive breast feeding
- Integrated management of childhood illness
- Strengthened health systems capacity
- Neonatal health (Mother-baby Package)
- Communication for Behavior Change

In the initial design of SALSA, the infant and child health component was scheduled to receive some 40% of the total funding. While total project funding has increased over time, the basic ratio of funding for infant and child health care has remained basically the same.

7.4 Achievement of Results

7.4.1 Growth promotion through community-based monthly monitoring of adequate weight gain and counseling

The MOH and its partners are addressing malnutrition of children under two years through growth promotion through community-based monthly monitoring of adequate weight gain and counseling. Volunteer Nutrition Counselors (VNCs), who work with the health promoter, are responsible for promoting infant/child growth (monthly weighing) and development. 946 volunteers have been trained nationwide; 342 facilitators have also been trained. More volunteers are needed and training continues.

What role do the Rural Nutrition Centers play in improving the nutritional status of the children that attend them? Should these centers include more activities in early childhood education and infant stimulation? Has the rehabilitation of these centers led to more mothers engaging in income-generating activities while the children are attended at the centers?

TABLE 5 presents rates of malnutrition: note that is twice as great in rural areas as in urban.

TABLE 5: Percent Malnutrition, Height for Age, children 3 to 59 months		
	malnutrition	Severe malnutrition
total	23.3	5.7
urban	14.8	3.0
rural	29.7	7.7

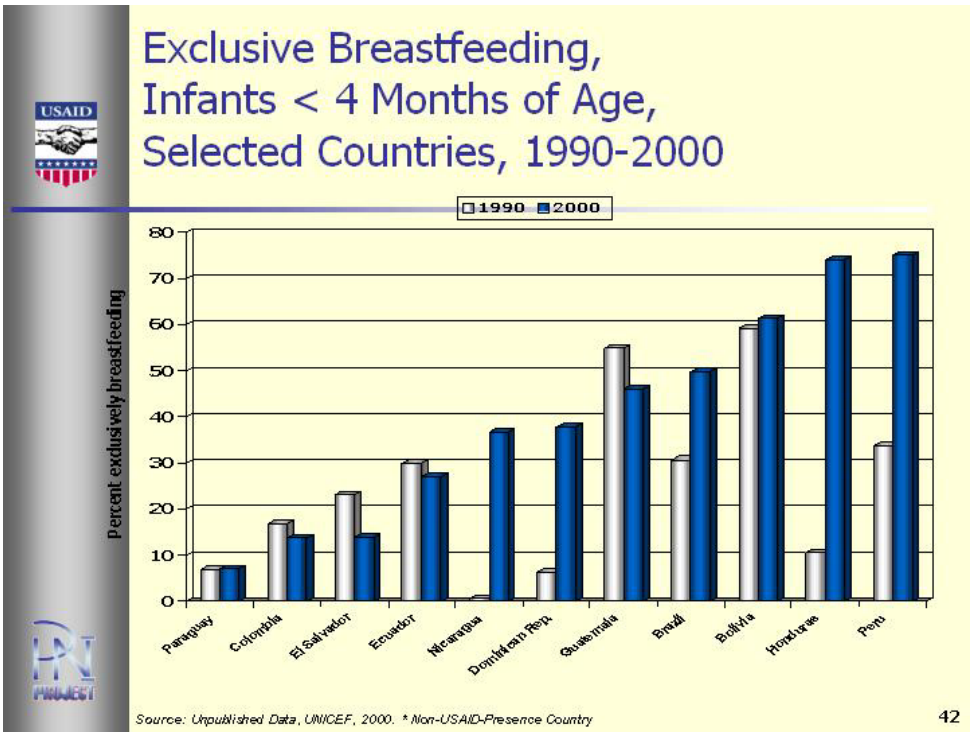
The team did not have time to review these centers in depth. However, their primary purpose does not appear to be improving the nutritional status of children, nor is the nutritional status (or economic status) of a child a criterion for admission to the center. They appear to be centers for early education; the team did not see any data on their facilitating mothers to engage in income-generating activities.

One possible new activity to better address malnutrition will be nutrition sentinel sites. The MOH, BASICS and USAID are discussing the possibility of establishing such sites nationwide which would:

- Establish a system of nutritional vigilance with basic indicators that will provide an early warning system about changes in the nutritional status of vulnerable population groups
- Identify nutritional trends in established sites nationwide
- Identify changes in nutrition, early.

7.4.2 Promotion of exclusive breast feeding

In El Salvador, data show that only some 21% of babies receive exclusive breastfeeding during the first three months of life, and another 28% receive breastfeeding predominantly. In Latin America, El Salvador has one of the lowest percentages of women providing exclusive breastfeeding for infants under four months. The following Figure, taken from a presentation to USAID/W, presents the problem.



The MOH, with the help of BASICS, has begun a facility-based self-monitoring system for the promotion of breastfeeding known as MADLAC. By the end of 2002, 27 of the nation's 28 hospitals had begun MADLAC. This year, continued efforts at the hospital and community level will be complemented by advocacy (National Committee on BF) to promote exclusive breastfeeding.

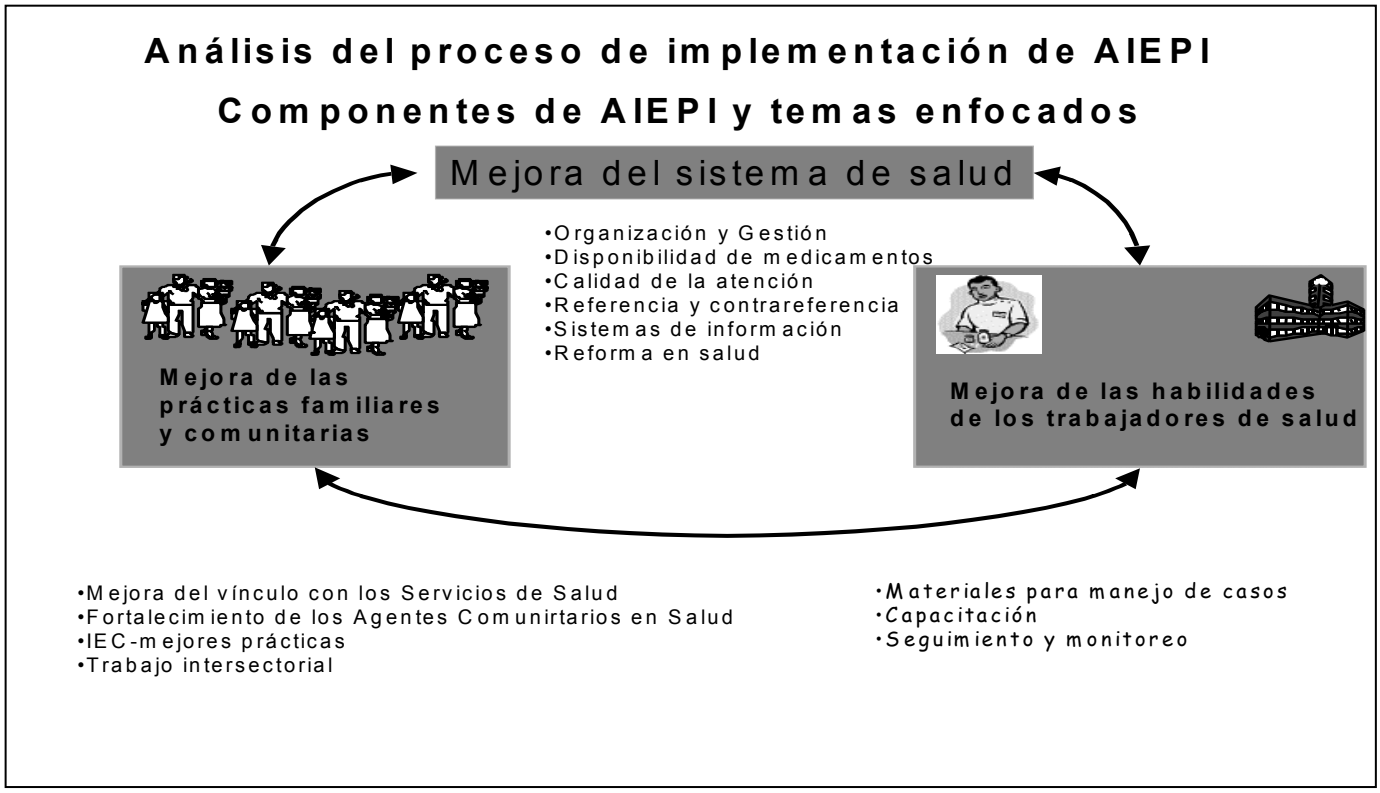
> ***How committed to increasing exclusive breastfeeding are MOH personnel at all levels? Are activities such as breastfeeding support being monitored at the hospital level?***
>
> It is not possible to generalize about MOH personnel at all levels after only a few interviews. BASICS has trained providers and facilitators in MADLAC which is self-monitored.

7.4.3 Integrated Management of Childhood Illness (IMCI)

IMCI has three objectives:

- Improving the skills of health workers
- Improving the health system
- Improving family and community practices

The following figure from a very recent evaluation of IMCI presents the three objectives and activities to achieve those objectives[23]



The MOH and BASICS have had real success in improving the skills of health workers, particularly health promoters who are the community implementers of IMCI. The number of health promoters trained in community IMCI is a USAID IR indicator. All MOH promoters have been trained and some PVOs (e.g. CARE), Red Cross and church-based organizations have also been trained.[24] Additionally, 97 health professionals, from the MOH and NGOs, have been trained as facilitators nationwide. Eleven courses on Clinical IMCI have been given to 385 doctors. Negotiations to incorporate IMCI into the Curricula of Medicine are taking place with the National University of El Salvador; one private university has incorporated IMCI in their pediatric curricula.

The evaluation of IMCI indicates very important achievements:

- The promoters are putting their newly acquired skills to work;
- They are providing systematized higher quality attention to children under 5 years;
- They are striving to detect high-risk children and refer them early on for attention; and
- There is improved epidemiological vigilance of childhood illness.

The evaluation, however, also noted weaknesses:

- Supervision and monitoring of promoters has been insufficient;
- Promoters have a tremendous (overwhelming) workload;

[23] *Premier Borrador del Documento de Trabajo, Analysis de la Implementacion de AIEPI El Salvador, Diciembre 2002*,

[24] The MOH in its October 2002 Quarterly Report noted that from October 1, 2001 to June 30, 2002, the MOH trained 1,622 health promoters, 100% of the health promoters working at that time. Nevertheless, there will be 89 promoters to train in 2003, due to new hires.

- Doctors and nurses have been insufficiently responsive in attending to referred children;
- There has been an uneven development of the various components of IMCI; the focus has been primarily on personnel development and less (insufficient) development of the health system and on family and community practices;
- There has been insufficient information and development of higher level health staff in the SIBASIs about the importance of IMCI at the primary level;
- Financial resources have limited the expansion of IMCI nationally; and
- There has been a shortage of necessary materials and equipment at the local level.

Striking in the evaluation is data on the shortage of utterly essential medicines in the community and in the clinics. 100% of interviewed health units indicated they were missing essentials, such as aspirin, iron, oral rehydration salts, and vitamin A. The reasons cited for the problem were lack of coordination and lack of interest. Eighty-six percent of SIBASIs indicated they knew medicines were not available in the health units: they specifically mentioned amoxicilina and penicilina sodica.

7.4.4 Neonatal health (Mother-baby Package)

In El Salvador, early neonatal (0-7 days) mortality accounts for about three quarters of the neonatal (0-28 days) mortality rate (17 per thousand). Neonatal mortality accounts for about 50% of infant mortality. As a result, the MOH, with the support of BASICS II, has placed a heavy emphasis on neonatal mortality, neonatal asphyxia, and care of the infant and mother. Activities include:

- Development of hospital perineonatal committees in 28 public hospitals and training in the Mother-baby Package (MBP).
- Twelve courses delivered in hospitals and universities on neonatal resuscitation, training a total of 411 people; 23 instructors were trained in neonatal resuscitation. They will continue to train; the goal is to have at least one trained person in each hospital or health unit where deliveries take place.
- 35 courses have been given in the "basic care of the newborn" training a total of 300 health personnel.
- Clinical guidelines on treating a healthy newborn and a sick newborn have been developed and are being finalized.

What has been the impact of SALSA/MOH strategies to improve newborn care on those newborns who aren't delivered in MOH hospitals (i.e., delivered by midwives or alone, etc.)?

TABLE 6: Urban and Rural Neonatal Mortality

	total	neonatal	postneonatal
total	35	17	18
urban	27	12	15
rural	41	21	21

In as much as 42% of infants are not born in a hospital, and rural mortality (41 per 1000) is much higher than urban (27 per 1000), as shown in TABLE 6, the role of the health promoter is critical. BASICS II has begun training all the health promoters in the identification of danger signs in a newborn. Basic skills in the management of a newborn are part of the health promoter training package. This training is recent; however, the effects may be seen in the FESAL 2003.

7.4.5 Communication for Behavior Change

BASICS has developed a multifaceted communications strategy (COSIN, Comunicación para la salud infantil) and accompanying materials to support behavior change targeted toward mothers (and other caretakers) and for use by clinical personnel as counseling aids. The communication strategy hopes to reach caretakers through radio (a radionovela), a brochure, posters in the clinic, a calendar, reminder stickers, a flipchart, etc. Clinic personnel can use the flipchart to support their counseling. These materials had not yet been distributed at the time of the Review Team's visit, however:

- The process of developing the strategy was excellent**.** Materials and messages were developed using a participatory approach with the involvement of key partner agencies and community validation. Focus groups were conducted to identify preferred learning approaches of mothers.
- The need for educational materials to facilitate effective counseling was observed during the hospital and clinic visits. Distribution of the new materials may help in promotion of IMCI. It would be useful to distribute these materials in the context of a workshop on how to use them and opportunities (e.g. role play) to practice using them. This workshop may be an effective vehicle to review and reinforce IMCI among clinic personnel.
- Develop an appropriate evaluation protocol for COSIN that acknowledges the multiple messages and media. The evaluation should be carefully crafted to ensure that implementers know which approaches were used and most effective.
- Complement one-way communication with sufficient two-way approaches. To effectively promote behavior change, one-way approaches (e.g. radio, posters, brochures) should be complemented with personal interaction (counseling in the clinic, group sessions or workshops using the materials, etc.). For example, the radio programs can be linked with educational sessions/discussions in the community facilitated by health promoters, combining the experiential with the auditory. In Nicaragua, there is a very successful telenovela that explores adolescent health issues. In the week after each program is aired, there are follow-up discussions in the community to discuss and process key messages.

What has been the impact of the SALSA/MOH strategies: IMCI, AIN, and Mother-Baby Package on child and infant mortality? Is the MOH monitoring these strategies adequately?

There has been real progress, as noted above, with various process outputs. Moreover, the MOH Quarterly Report of October 15, 2002 indicates that in the first six months of 2002, the MOH achieved 83% coverage of under 12 month old children with the pentavalente vaccine that includes DPT3. In 1998, the coverage for DPT3 was 65%; the goal for 2003 is 68%.

Data on impact indicators will come from the 2003 FESAL. While one can expect there will be national impact from national efforts (work on promoters' job descriptions, development of promoters' skills, development of IMCI protocols, training in care of newborns etc), one must be mindful that a good deal of MOH/BASICS' work has been early efforts – work that must be adopted as national models in order for there to be national impact. Clinical IMCI must be pushed: the health units must get moving and adopt the strategy.

7.6 Future Directions to Consider

1. Analyze the rural nutrition centers to determine if their primary use is health or early childhood education; if it is early childhood education, consider if USAID's Office of EGE could take the lead in assisting these centers;

2. Establish nutritional sentinel sites to monitor nutrition among acutely vulnerable populations;
3. Continue to provide high level support and continuous efforts to promote breastfeeding at the hospital level and with health promoters, nutritional volunteers, and parteras;
4. Continue development of IMCI, ensuring that promoters correctly apply the protocols they have learned (community IMCI) and strengthening those clinical areas that are relatively underdeveloped, as identified in the recent evaluation (clinical IMCI);
5. Continue to train health personal in neonatal care and reach goal of one trained person in each hospital/health unit in which deliveries take place;
6. Provider greater support, supervision and monitoring for the promoters: ensure that they have a "doable" workload; consider creating an oversight office in the MOH for promoters; and
7. Consider adding a birth spacing activity in the new strategy.[25]

8. REPRODUCTIVE HEALTH

8.1 The Problem

Although the maternal mortality ratio had fallen in 1998 compared to 1993, it continues to be unacceptably high at 120 maternal deaths per 100,000 live births. The 1998 total fertility rate (TFR) of 3.58 varies greatly from urban to rural areas. Many rural departments have a TFR over 4; one department, Cabanas, has a TFR of 5.15. Unmet need for family planning is high among the rural poor and among adolescents. TABLE 7 presents SO indicators for reproductive health.

Table 7: SO Indicators for Reproductive Health in USAID/El Salvador's Strategic Framework

SO indicators	Source of verification	frequency	Issues
maternal mortality ratio - proxy = % deliveries by trained personnel	MOH FESAL	Annually Every five years	Data available on % of deliveries in hospitals – by doctors (trained) and nurses (most of whom have not been trained in obstetrics)
total fertility rate	FESAL	Every five years	CPR and CYP can be proxies to gauge progress. MOH reports quarterly on MOH CYP, however, it is important that MOH and USAID analyze CYP and CPR for the national program. The MOH is the source of supply for 47% of MWRA who are using contraception; tracking CYP quarterly presents MOH progress. For sustainability, however, it is important to periodically analyze the "health" of the other sectors in the national program.

IR1: "Access to quality health-related services increased"

[25] Children born 3 to 5 years after the previous child are about 2.5 times more likely to survive to age five than children born less than 2 years after the previous child, according to the report, Birth Spacing: Three to Five Saves Lives. The new findings come from the Demographic and Health Surveys (DHS) program, which analyzed outcomes of more than 430,000 pregnancies in 18 countries. A review of the report noted, "In every country thousands more children could survive each year if all women spaced their births at least 3 years apart," according DHS estimates cited in the report. In Nigeria, for example, if all couples space births between 3 to 5 years, deaths of children under the age of five could fall by 23%. Similarly in Pakistan, death of under-five children in Pakistan could fall by as much as 46%, if all women spaced their births 3 to 5 years apart, according to the Hopkins report. Unfortunately, in many countries, spacing births beyond three years is far from the current practice and as a result many lives are still being lost."

- ✓ "Phase-out plan for USAID-financed contraceptives developed and agreed upon by GOES and donors"
- ✓ "% of clients satisfied with reproductive health services"
- ✓ "% of family planning service delivery points stocked according to plan"

IR2: "Use of health-related services/practices increased"

- ✓ Contraceptive prevalence rate: proxy CYP
- ✓ # of people treated for STIs

8. 2 Partners: MOH, SDA, PRIME II, FHI, DELIVER, CDC, Georgetown

8.3 Activities

TABLE 8: USAID Funding for RH

Activity	Timeframe	Funding level	Comments
MOH SALSA RH component	8/98 to 6/05	$3,889,597	First year SALSA plan projected 38% of SALSA funds for RH; through 9/02, 19% of total has been spent on RH. PRIME indicates RH is underspent because all training was canceled due to earthquakes and because new MOH purchasing law has resulted in purchasing delays, including purchases of RH hospital equipment
PRIME	1998-2002	$3,215,000	TA to MOH: adolescent RH; cervical cancer prevention and diagnosis; primary level family planning; prenatal, delivery, postpartum and Postabortion care services; obstetric emergency; quality of care; and ,management development (logistics) PRIME success in modeling new ARH practices in three regions and prenatal/postpartum and PAC in six regions. Recent internal evaluation recognizing need for greater strategic focus and realignment of project with 7 SIBASIs
Deliver	2000-2002	$400,000	TA to MOH and to SDA on contraceptive phase out
Central Contraceptive Procurement	1998-2002	$2,141,011	See Annex F for a breakout.
subtotal		$9,645,608	
SDA	7/99 to 12/02, extended to 6/05	$9,000,000 (to be increased to $13,000,000)	Recent sustainability assessment has led to extension of agreement to 2005. SDA indicates with extension they will strengthen for-profit activities, enabling cross-subsidization to the rural program and the adolescent program.
Central Contraceptive Procurement subtotal	1998-2002	$2,087,913 15, 087,913	See Annex F for a breakout.
total		$24,733,521	

What has been the impact of centrally-managed, core-funded activities in the area of reproductive health in El Salvador?

The Mission currently oversees seven core-funded activities of five American CAs and has requests for concurrence for three additional activities. Some activities are directly related to

USAID/El Salvador's priorities (network of adolescent friendly pharmacies), while others are less directly related (randomized controlled trial of two vasectomy techniques, social responsibility, a proposed study to compare impact on bleeding and discontinuation rate between two methodologies of delivering oral contraceptives, validation of a survey-based approach for predicting willingness to pay for RH services and, the study and implementation of the Standard Day Method of FP, "El Collar", in selected communities.)

To date, the impact appears to have been minimal. However, the Mission reports that these activities constitute a considerable management burden for an office that already has, through its bi-lateral and field support activities that serve USAID/El Salvador's SO, a heavy work load. Moreover, the Mission notes that there have been occasions when a centrally-managed project has come into El Salvador without Mission awareness and concurrence and the Mission has had to step in. Obviously, situations like this further increase the management burden without contributing to the achievement of the Office's SO.

8.4 Achievement Of Results

8.4.1 IR1: "Access to quality health-related services increased"

"Phase-out plan for USAID-financed contraceptives developed and agreed upon by GOES and donors"

USAID has provided contraceptives to EL Salvador for many years; it has been the largest donor (UNFPA has also provided support.) Historically, USAID has supplied contraceptives (orals, injectables and condoms)[26] to the MOH and SDA, which together were the source of supply for 63% of users in 1998 (MOH for 47.1%, SDA for 15.6%). Since 1993, USAID has supplied $4,509,640 worth of contraceptives, 46.3% to MOH, 47.4% to SDA and 6.4% to ISSS. See the TABLE in ANNEX F that presents USAID's contraceptive provision from 1993 through 2001.

USAID's concern at this point, as it anticipates phase-out, is that there be access (geographic, economic, psychological etc) and quality to meet the growing needs of Salvadoran women (couples) after USAID phase-out, to be completed, as currently envisioned, by 2005. In 1998, of those women using contraception, 31% of urban women, 33% of rural women and 71% of adolescents were using contraceptives such as USAID has supplied. What's at stake here is access for many women, most particularly, adolescents.

The MOH has developed the following goals and mechanism for their strategy to achieve contraceptive self-sufficiency:

1. Design and implement a phase-out plan within the MOH.
2. Improve the monitoring of local logistics systems.
3. Develop plans and budgets to include allocation of contraceptive purchases.
4. Updating of contraceptive methods in the Essential Drug List.
5. Purchase contraceptives through UNFPA.

In 2002, USAID did not place an order for contraceptives for the MOH; an order for 2003 for orals and injectables has been placed. USAID and the MOH will review this order in light of the increases in consumption rates that the MOH has been experiencing. In early December 2002, they will review projected contraceptives needs for 2003, 2004 and 2005 with the TA of the DELIVER project. Based on

[26] USAID has also supplied IUDs, of which there has been a surplus in El Salvador, leading to the need to ship IUDs to other nearby USAID programs.

this revised projection of needs, USAID and the MOH will revise the phase-out plan presented in TABLE 9 that projects that 2004 will be the last year for USAID contraceptives to the MOH.

TABLE 9: MOH Phase-out TABLE for USAID-donated Contraceptives			
	orals	injectables	% funded by USAID
2003	$118,800	$236,4000	73%
2004	0	$156,000	57%
2005	0	0	0

It is unknown for how many years UNFPA will supply contraceptives to El Salvador, nor what will happen when/if that source should dry up. In as much as rural and adolescent women, two population groups of particular USAID concern, are most dependent on reliable supplies of orals, injectables and condoms, and have the least ability to pay for contraception, it is essential that USAID be sure that adequate contraceptives are accessible. USAID, the MOH and UNFPA should continue discussion and build a clear understanding of UNFPA's plans, including both a timetable and resource allocation for contraceptive security.

SDA, which has promoted family planning for 40 years in El Salvador, is the other recipient of USAID contraceptives. SDA service delivery points include 10 SDA clinics, 1 SDA hospital, 3 SDA drug stores, and 51 reproductive health centers in the private sector. SDA also has 853 rural health promoters who provide counseling, condoms, orals and injectables, and referrals for other methods, in all 14 departments. Promoters also provide counseling and referrals on other child and maternal care.

SDA offers high quality care with a high level of customer satisfaction, as well as carries out other services that benefit the national program (research and advocacy). For these reasons, USAID has invested heavily in SDA and has sought to ensure its sustainability upon USAID phase-out. A particular concern has been the sustainability of SDA's rural family planning program because unmet need is highest among the rural poor.[27] The current phase-out plan , developed between USAID and SDA, indicates SDA will pay 15% of the costs of all contraceptives in 2003, 50% of the costs in 2004, 85% of the costs in 2005 and 100% of the costs in 2006. With phase-out of USAID support, SDA anticipates a reduction in rural program by 20% by 2005.

"Family planning service delivery points stocked according to plan"

"Family planning service delivery points stocked according to plan" is an important USAID indicator of achievement of USAID's strategic framework; the indicator formally measures only stocks at MOH health facilities. The MOH 2002-2003 Action Plan has a goal of 90% of Unidades being stocked with temporary methods. A first step (Oct-Dec 02) is to establish the basic method mix and minimum/maximum for the units. No baseline data was seen.

Although the USAID indicator only measures facility-based stocks, community level stocks are also absolutely vital. The MOH 2002-2003 Action Plan has a goal of 80% of SIBASIs' distributing contraceptives at the community level through promoters and parteras. A PRIME study (April 2000) indicated 85% of promoters had condoms, 65% orals, and 47% injectables. This study identified a number

[27] A May 2002 Assessment of SDA Sustainability noted, "An overall concern of USAID is to determine whether or not the SDA has the financial capability to absorb the purchase of USAID-funded contraceptives. The premise of the consultants is that, based upon the financial analysis of the institution and its free cash flow capacity, (as documented in this report) it is feasible for the SDA to purchase its own contraceptives, but at a cost to the program, both in quantity and quality of services and to the SDA's long term financial sustainability efforts. Therefore, any phase-over strategy in the area of contraceptive procurement must take into consideration these factors."

of obstacles promoters face: inconsistent and insufficient stocks supplied by the Unidades, Unidad support for promoters serving only follow-up clients, and doctor/nurse opposition to promoters' providing injectables. Moreover, an August 2002 study indicated that nationally 25% of promoters did not provide contraceptives; in the Occidental zone, 45% did not.[28] The 2002-2003 Action Plan anticipates sensitization meetings so that community-based providers are stocked. The Review Team recommends that USAID and MOH leadership closely monitor the process and outcome of these meetings and that the MOH move forcefully to ensure that SIBASIs and Unidades provide contraceptives, training and supervision for community-based distribution (CBD).

SOW Question: What has been the result of USAID support for MOH and SDA in the area of contraceptive logistics and supply? Is there sufficient commitment from MOH in terms of fully implementing and monitoring USAID-funded innovations to the contraceptive logistics system?

As the preceding text indicates, there must be hard and determined MOH work ahead to assure a contraceptive logistics and supply enabling access at the Unidad and community level. There appears current commitment to such work. Current work with SDA is focused on phase-out and financial sustainability.

8.4.2 IR2: "Use of health-related services/practices increased"

This section presents increases in the following health-related services/practices, which most directly impact upon maternal mortality:[29]

- Family planning (contraceptive prevalence rate: proxy CYP)
- Pre and postnatal care
- Hospital deliveries, which is the proxy for percentage of deliveries attended by trained personnel (itself the proxy for maternal mortality ratio)
- Postabortion care

Additionally, this section discusses client satisfaction, which is a critical factor in a women's decision to use health services.

Family planning

The contraceptive prevalence rate (CPR) is the USAID indicator for an increase in the use of family planning. CPR rose among all population groups from 1993 to 1998. There remain, however, major gaps between the urban and rural areas as TABLE 11 indicates.

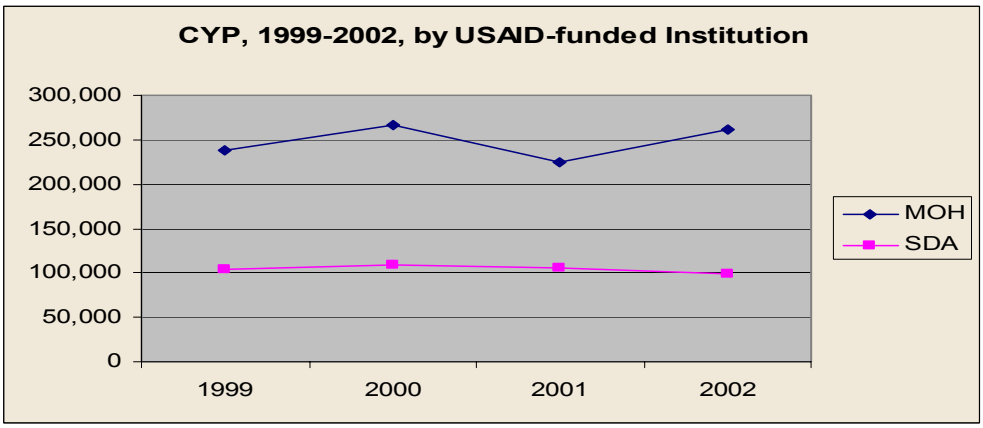
TABLE 10: CPR, MWRA, 1993-1998

	1993	1998
total	53.3	59.7
urban	61.3	67.8
rural	45.6	51.2
adolescents	22.5	33.4

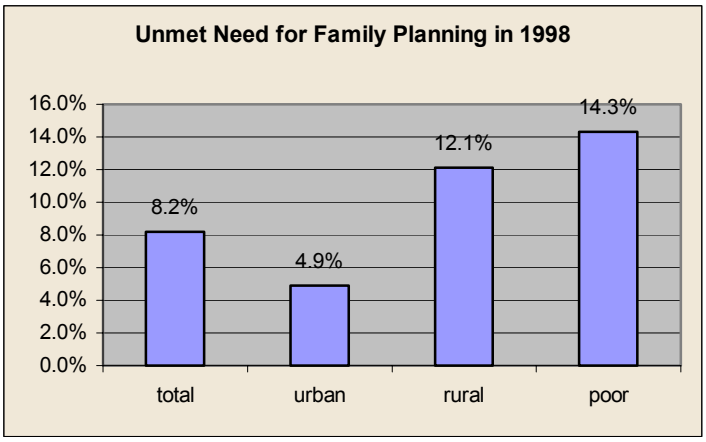
[28] Ramirez, Esmeralda and Luz Elda de Aguirre, *Informe Tecnico Sobre Resultados de Evaluacion Programa de Planificacion Familiar*, MSPAS, Agosto de 2002

[29] USAID is also supporting prevention and early detection of cancer in three cervical care clinics in the MOH and emergency obstetrical care (EOC). The team recommends dropping cervical cancer because it is not related to USAID's SO. USAID's work in EOC has taken place in one small area of the country, Ciudad Barios; the team did not review this activity.

Couple Years of Protection (CYP) is the proxy indicator for USAID. The Figure below shows CYP from 1999 to 2002 (projected for the last six months of 2002), for the SDA and MOH. CYP fell in 2001 for both the MOH and SDA due to the earthquakes when the health infrastructure was damaged. CYP in 2002 appears to be the same level as 2002 for the MOH and slightly less for the SDA, which has reduced the size of its rural program. CYP must grow at least 2% (the rate of population growth) for CPR to remain level. To meet the unmet need in the country, it must exceed that rate.



Nationally, the unmet need for family planning was 8.2%; however, the need was two and a half times as great in rural areas as it was in urban. It was almost four times as great among poor women (14.3%) as it was among high income women (3.7%). In 1998, the average time of a rural MWRA who was not using contraception but desired to use a method and knew where to get one was almost an hour.



SOW Question: Given the current CPR and unsatisfied demand for contraceptives in EL Salvador, what should be the focus of USAID's family planning program over the next two years? Where are the gaps?

The focus should be ensuring that 100% of rural promoters and parteras have been trained in counseling and providing family planning, that 100% have adequate supplies of orals, condoms and injectables provided by local Unidades, and that they know where and how to refer for other methods. The obstacles identified previously should be addressed in the next two years.

Pre and postnatal care

Improved and increased pre/postnatal care is one component of the SALSA program. MOH promoters and parteras should be counseling women on the importance of prenatal care and referring them to the nearest Unidad for prenatal care. All pregnancies carry the risk of complications that are largely unpreventable and unpredictable. Prenatal care is important because it provides an opportunity to teach women to recognize complications early and to seek EOC promptly, if necessary. Prenatal care is valuable because it is a means to facility-based deliveries, which are correlated with better health outcomes. Unidades, promoters and parteras should be working with their local communities on effective

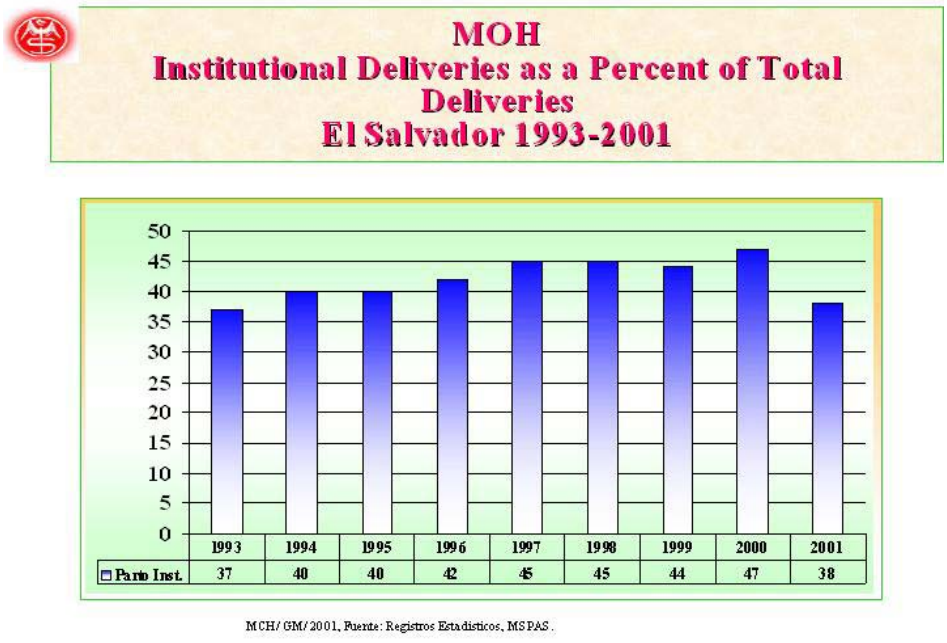
referral systems and delivery plans that realistically link women with trained providers, including means of transport and payment of fees.

Hospital deliveries

In the Mission's Framework, the percent of deliveries attended by a trained provider is a proxy for the maternal mortality ratio. Throughout the world, there is recognition of the correlation between attendance by a trained provider and health outcomes. The 1998 FESAL presented the following profile of the place of delivery for urban and rural women. While almost 78% of urban women delivered in a hospital, only 43% of rural women did.

TABLE 11: Place of Delivery				
	hospital	Midwife (partera)	At home alone or with others, or other unassisted birth	total
National average	58.0%	34.4%	9.6%	100%
Urban	77.8%	17.0%	5.2%	100%
Rural	42.7%	44.3%	13.0%	100%

Getting women to deliver in a hospital has been a challenge for many years. The following graph presents the trend line for 1993-2001. MOH data of October 12, 2002 indicates that for the first six months of 2002, 42% of deliveries were attended (in a hospital). This is the same rate as 1996; there has been little appreciable progress in six years.



The MOH has tried a number of strategies over the years to increase the safety of childbirth. In the past, midwives were trained, certified and provided a basic delivery kit. More recently, Unidades de Salud, with USAID support, have reached out to midwives and offered them monthly meetings during which they discussed problems and reported on cases within their local area. The MOH guidance to midwives (and promoters) is that they must refer first pregnancies and high-risk pregnancies to a local hospital.

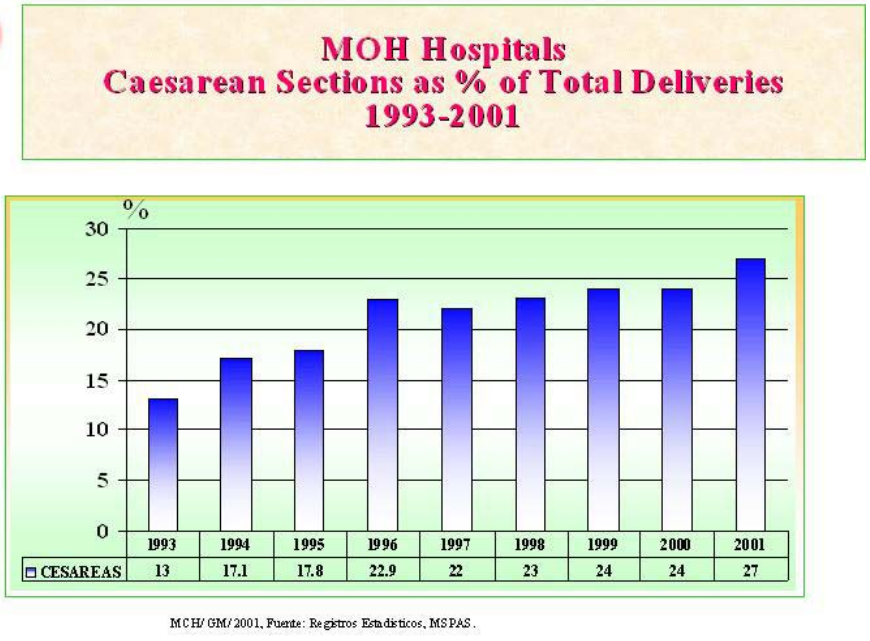
In El Salvador, delivery in a hospital has been the proxy for delivery by a trained provider. Most deliveries in a hospital are attended by a doctor (who has been trained). In a 1998 study, data from nine

large hospitals indicated that on average, doctors attended 88% of the births.[30] The range, from hospital to hospital was large: 66% to 99%. Nurses attended, on average, 5% (range was 23% to 1%) and auxiliary nurses attended, on average, 7% (range 21% to 0%). Nurses and nurse auxiliaries have not have received obstetrics training in school and thus unless they were one of the approximately 60 nurses trained by PAHO (out of 3000 in the country), these hospital deliveries would not technically be by a trained provider.

Training nurses and taking advantage of the Unidades de Salud and Casas de Salud appears one realistic way to enable facility-based deliveries. PRIME indicated that it hopes to train all appropriate nurses in obstetrics in the seven USAID-focus SIBASIs; however, the MOH action plan does not identify specific resources to do so. If it should not be possible to train all appropriate nurses, PRIME and the MOH, at a minimum, should be working with those SIBASIs to adopt lessons learned in pilot areas on quality of care improvements and work with the promoters and midwives at the community level.

As TABLE 12 above indicates, rural women are almost twice as likely not to deliver in a hospital as urban women. According to the FESAL, hospital delivery is positively correlated with socioeconomic level, with education and with parity. 71% of first deliveries were in a hospital; the percentage decreases with each additional delivery.

Studies report a number of reasons why women rural women prefer a midwife to a hospital. Cultural traditions favoring midwives are strong. However, two reasons frequently cited, particularly by adolescents, are hospital-based: opposition to/fear of, a Cesarean Section and an episiotomy. In 2001, 27% of all deliveries nationwide was by C-Section. The range from department to department was great, from a high of 42% in San Salvador to a low of 14% in Cabanas.[31]



Moreover, the trend toward higher rates of C-Sections has been steady since 1993, when it was 13%, as this graph indicates.

Opposition to/fear of an episiotomy is another reason for choosing a midwife. MOH hospitals assisted by PRIME in their pilot sites show impressive results in lowering the rates of both C-Sections and episiotomies. In

[30] Dr. Carlos Melendez Osorio, *Investigaciones en Salud Reproductiva, Acciones en la Salud Perinatal en El Salvador, Situacion de la Atencion del Parto y Del Recien Nacido en Los Hospitales de Ministerio de Salud Publica y Asistencia Social*, (powerpoint presentation), El Salvador, 1998

[31] MSPAS, *Principales Indicadores Relacionados Con La Salud de La Mujer, Ano 2001, Tendencias 1993-2001*, El Salvador, Diciembre 2001

Sonsonate, the National Hospital reduced the rate of C-Sections from 28% in 2000, to 24% in 2001, to 22% for the first nine months of 2002.[32] It cut the rate of episiotomies on women with first deliveries from 94% in the first eight months of 2001 to 37% in the first eight months of 2002.[33]

Post abortion Care

Postabortion care (PAC) is another MOH innovation, supported by PRIME. The MOH has introduced improved postabortion care into three pilot sites. The program is identified as PAC/PP (postabortion/postpartum IUD). In Sonsonate, the Hospital Director reported that about 48% of women reporting to the hospital with postabortion complications were treated with manual vacuum aspiration equipment (MVA) and the other 52% with dilation and curettage (D&C).[34] He reported high levels of satisfaction on the part of both women and hospital staff. Women treated with MVA usually stayed in the hospital a few hours (rather than several days with a D&C). PAC services were available seven days a week/24 hours a day. Hospital staff welcomed the savings involved with a MVA over a D&C (for those women for whom MVA was appropriate). The hospital estimated it had saved $16,212 since it initiated the new PAC strategy.

The Review Team did not have time to examine the PAC strategy in this or any other hospital. The team suggests the Mission might want to read the USAID/W global evaluation of PAC undertaken last year.[35] It discusses three essential interrelated components of PAC: treatment of complications, family planning, and referral for other reproductive health care. Since that evaluation, USAID/W has updated the PAC model to include five essential components.

Essential Components of Postabortion Care

1. Community and service provider partnerships
2. Counseling
3. Emergency treatment for complications of spontaneous or induced abortion
2. Postabortion contraceptive and family planning services
3. Reproductive and health services

"Clients' satisfaction with reproductive health care"

Client satisfaction with the reproductive health care received is a USAID indicator and a critical factor in the sustainability of such services. USAID has data on client satisfaction with family planning and with adolescent care; there is national data (FESAL) and data on satisfaction with care in the MOH and at SDA. USAID is working with its partners to ensure increased client satisfaction.

The 1998 FESAL posed the question, "If in this moment you could choose, would you prefer to use another method or would you continue using the same method?" Eighty-five percent of respondents said they would choose the same method, indicating satisfaction with their family planning choice. At that time, however, 30% of teens said they would choose another method, no method or didn't know.

[32] verbal report during site visit
[33] Hospital powerpoint presentation
[34] verbal report during site visit
[35] Laurel Cobb, Nicole Buono, John Dunlop, Pam Putney, Roger Rochat, Julie Solo and Mary Vanderbroucke, *"GLOBAL EVALUATION OF USAID'S POSTABORTION CARE PROGRAM"*, POPTECH, January 2002

A year later, in an FHI study, problems with counseling and client satisfaction were identified.[36] In response, USAID with the technical assistance of FHI, carried out a series of Contraceptive Technology Updates (CTUs) with health providers and managers to upgrade their capacity to provide better, more accurate and complete counseling. Additionally, intensive work began to update the outdated Family Planning Norms, with very broad participation of several sectors (MOH, NGOs, ISSS, ADS, Universities and OB/GYN Society); training in the norms and new National Standards in FP were important steps in ensuring informed choice. USAID is continuing to promote counseling and informed choice: the MOH Action Plan 2002-2003 including activities to improve the informed consent forms and procedures.

A broad method mix, to both space and limit, is one way to increase client satisfaction. Historically, however, women wanting to limit their family size in El Salvador have relied almost exclusively on voluntary surgical contraception (VSC). VSC is an excellent method for women who are absolutely sure that they will never again, under any circumstances, want another child. For women with any margin of doubt, however, it is essential there be long-term, non-permanent methods. The IUD is such a method and USAID should continue to support its greater availability in El Salvador.

Safe and effective new forms of contraception, for spacing and limiting, are always desirable. Georgetown has been undertaking research on the "Standard Day Method" in El Salvador. When that research is completed and if the research results are positive, the Mission will discuss the method with the MOH. Should the MOH choose to integrate the "Standard Day Method" with other methods supplied in the public sector, the Mission will request standard guidance from the Services Division of Global Health and the technical assistance of PRIME for the process.

Adolescent Reproductive Health Care

USAID, with the MOH and PRIME, has a two-pronged pilot program with adolescents in three departments. The first prong has sought to make services friendly to adolescents, hoping thereby to encourage pregnant adolescents to attend prenatal care, deliver in the hospital, receive postpartum care and make deliberate decisions about their future. The results are very favorable. As a result of qualitative research on adolescents' perceptions of care, development of new protocols, extensive staff training, and efforts to reduce the rate of episiotomies (dreaded by adolescents), the percentage of teenagers who rated their hospital experience "good" increased from 84% to 95%.[37]

The second aspect, just beginning, is community-level education and promotion through peer adolescent community leaders. As mentioned in Section 10, PRIME is currently validating a manual for developing such peer leaders.

Are USAID activities supporting significant improvements in maternal health? If not, why not?

On a pilot basis, there has been impressive progress in the hospitals/surrounding communities with MOH/PRIME activities in adolescent health, prenatal/delivery/Postabortion care, and COPE. Data on increasing FP use, increasing hospital delivery, decreasing rates of Cesarean sections, and adoption of more comprehensive and less invasive postabortion care indicates there should be improvements in maternal health in those catchment areas. Additionally, MOH/PRIME activities at the national level (training, development of norms, etc) should lead to improved maternal health.

[36] Family Health International, *Evaluacion Cualitativa de Necesidades para la Actualizacionde la Tecnologia Anticonceptiva en El Salvador*, Reporte Final, July 1999

[37] PRIME II, *Estudio Comparativo, Impacto Sobre La Calidad En La Atencion que Reciben Las Adolescentes Puerperas en Los Hospitales de Usulutan, Sonsonate y La Paz*, Mayo 2, 2002

However, the Review Team has not seen any data to date to indicate improvements at the national level. Certainly Hurricane Mitch and the earthquakes were terrible impediments to progress. Delays in purchasing were an impediment. However, in order to have impact at a national level, the MOH will have to take essential RH programs/innovations to scale through the development and dissemination of national norms and protocols.

Future USAID programming will have to balance focus on the seven USAID-assigned SIBASIs that have 19% of the nation's women of reproductive age with efforts to improve maternal health on a national level. Hospitals in the USAID-focus SIBASIs account for about 24% of all MOH deliveries. To have national impact, the MOH will have to adopt MOH/PRIME programs and the innovations in reproductive health presented here (reduced rate of C Sections, reduced rate of episiotomies and improved PAC) on a national level – that is, in 28 SIBASIs.

8.5 Future Directions to Consider
(see also Section on Adolescents)

Increased access to quality health-related services

1. Deepen USAID/MOH/UNFPA discussions on contraceptive security and build a clear understanding of UNFPA's plans, including both a timetable and resource allocation for contraceptive security;
2. Strengthen the direction (norms, standards, policies) and supervision supporting the promoters' provision of counseling, orals, condoms and injectables in the community - make successful CBD a priority and significantly reduce rural unmet need for family planning;
3. In line with strengthened direction and supervision, ensure smooth, reliable and adequate contraceptive supply and broad method-mix in the SIBASI agreements, at least in the seven USAID-focus SIBASIs, including reliable and adequate stocks at the community level;
4. Continue efforts to promote the IUD as a safe, effective and satisfactory method of long-term contraception; provide contraceptive technology updates and training on the IUD to appropriate personnel in the seven USAID-targeted SIBASIs;
5. Develop and implement strategic plan for scaling-up PRIME successes in improved quality of reproductive health care (adolescent reproductive health, EOC, PAC and other improved hospital care etc.) to the new seven USAID-focus SIBASIs;
6. Develop and implement plans, at least on a pilot basis, for training appropriate nurses in obstetrics and for equipping Unidades and Casas de Salud for deliveries.

Use of health-related services/practices increased

7. Undertake follow-up study on client satisfaction with contraception;
8. Intensify efforts with Unidades, promoters, parteras and communities on effective referral systems and delivery plans that realistically link women with trained providers, including means of transport and payment of fees.

National Impact

9. Convene all donors for RH in the 28 SIBASIs, map out national coverage and goals, plan collaboration and sharing of lessons learned and progress made.
10. Share (with El Salvador RH community) the benefits to the woman and to the health system of appropriately reducing the current high rate of cesarean sections.
11. Share (with El Salvador RH community) the benefits to the woman and to the health system of comprehensive postabortion care.
12. Consider selective support of SDA, in light of its contribution to the national program in terms of its reproductive care, as a center of excellence in research and advocacy.

USAID Focus

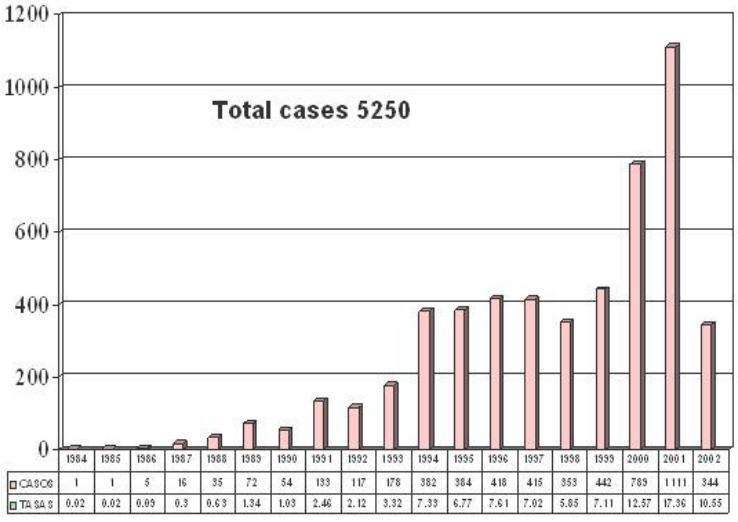
13. On an on-going basis, prioritize activities in terms of their contribution to USAID/El Salvador objectives and to the national program; drop those programs such as cervical cancer that do not contribute to USAID's SO.
14. Evaluate proposals for new core-funded activities in terms of their contribution to USAID objectives and to the national program, in light of the consequent management burden.
15. Considering the existing heavy management burden in reproductive health, consider that burden when making decisions about focus, scale-up and expansion of reproductive health activities

9. HIV/AIDS

9.1 The Problem

HIV/AIDS in El Salvador is a concentrated epidemic that has grown rapidly since the first documented case was reported in 1984. The MOH and other HIV/AIDS health professionals estimate there are 25,000 to 50,000 HIV/AIDS in the country. Documented cases are a fraction of that total. The following graph shows the growth of documented HIVs cases through July 2002. The 2002 total under represents the number for the period, in part, because some institutions wait until the end of the year to do complete statistical reporting for the year.

EL SALVADOR AIDS CASES
1984 to JULY 2002



	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CASOS	1	1	5	16	35	72	54	133	117	178	382	384	418	415	353	442	789	1111	344
TASAS	0.02	0.02	0.09	0.3	0.63	1.34	1.03	2.46	2.12	3.32	7.33	6.77	7.61	7.02	5.85	7.11	12.57	17.36	10.55

Fuente: Programa Nacional ITS/VIH/SIDA.
Ministerio de Salud Pública y Asistencia Social

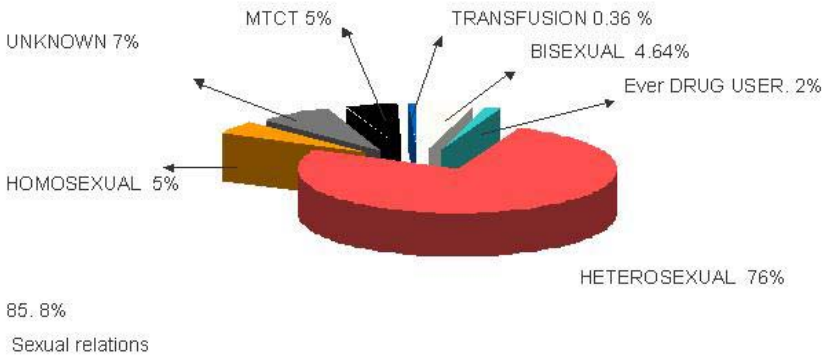
In addition to the 5250 documented cases of AIDS, the MOH reports a total of 4862 documented cases of HIV through July 2002. As with AIDS, these are believed to be only a fraction of the total and this number does not represent seven months of cases as some institutions wait until the end of the year to do complete statistical reporting for the year.

MOH data indicates sexual relations, primarily heterosexual, are the means of transmission for 85.8% of documented AIDS cases.[38] Homosexual, bi-sexual and Mother to Child Transmission (MTCT) account for approximately the same percent of documented cases: 5%.

[38] The numbers of heterosexual cases may reflect a bias since many males who have sex with men are also having sex with females, but due to stigma, will only admit having sex with women.

AIDS TRANSMISSION CATEGORY

El Salvador, 1984 to July 2002

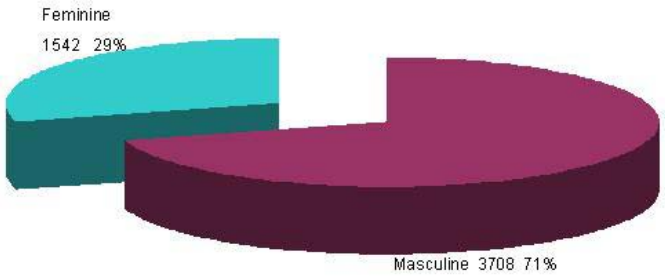


SOURCE: PROGRAMA NACIONAL DE ITS/VIH/SIDA
Ministerio de Salud Pública y Asistencia Social

Seventy-one percent of documented cases are men.

Cases of AIDS by Sex

El Salvador, 1984 to July 2002



FUENTE PROGRAMA NACIONAL DE ITS/VIH/SIDA
Ministerio de Salud Pública y Asistencia Social

Adolescents and young adults comprise 16 percent of AIDS cases.

TABLE 12: Indicators on HIV/AIDS in El Salvador			
Indicator	1995	2001	source
Rate of AIDS among women x 100,000	3.21	12.13	MOH
Rate of AIDS among men x 100,000	10.44	22.02	MOH
Rate of HIV among children under 5 years x 100,000	4.87	6.35	MOH
% of heterosexual transmission	NA*	76.9%	MOH
% of homo/bisexual transmission	NA	5.1-4.4%	MOH
% of perinatal transmission	NA	4.6%	MOH
% cases in San Salvador	NA	58%	MOH
% of men having sex with men (MSM) without protection	37%	78%	PASMO 2001
% of commercial sex workers having sex (CSW) without protection	78%	35%	PASMO 2001
Prevalence of HIV among men having sex with men	NA	17.8% (2001)	PASCA 2002
Prevalence of HIV among commercial sex workers	NA	3.9%	PASCA 2002
Relative reported cause of death in hospitals	NA	ninth	MOH
% of health expenditures on AIDS	NA	1% (1999)	MOH

NA = Not available

9.2 The Partners: MOH, PASMO, PASCA, AED, CHANGE, PNC, ANSP

9.3 Achievement of Objectives

Health Strategic Objective- *Health of Salvadorans, Primarily Women, Youth and Children, Improved.*

9.3.1 Indicators

IR 2. Use of Health Related Services/Practices Increased
Indicator 2.c: "Number of people treated for STIs"

Sub-IR 2.1 Policies Supporting Use of Health Related Services/Practices Strengthened.
Indicator 2.1a: "legislation passed to decrease HIV/AIDS discrimination"

Sub-IR 2.2: Health-seeking Behaviors Increased
Indicator 2.2b: "knowledge of HIV prevention methods among high-risk groups"[39]
Indicator 2.2c: "number of condoms sold"

9.3.2 Activities

Through SALSA

- IEC materials
- Bio-security measures
- HIV/AIDS patient protocols
- HIV/AIDS counseling
- Pediatric AIDS
- Hotline
- Sexuality Education

[39] MV note- This indicator does not seem to measure Sub-IR 2.2 "Health seeking behaviors increased" as it is measuring "knowledge" not behavior. I suggest the Mission rethink this indicator. Indicator examples are given below.

Through G/CAP

- *PASCA* Multi-site seroprevalence studies among commercial sex workers and MSM in Acajutla and San Salvador.
- Advocacy through 3 Alliances established to work on: legislation, treatment, and adolescents.
- ACCION SIDA (community organization) activities in La Libertad and Morazan.
- *PASMO*: Social marketing of condoms to high-risk behavior groups to promote behavior change.

Surveillance And Voluntary Counseling and Testing (VCT):

- National Surveillance/Data for Decision Making
- CDC assessment
- VCT one-day pilot sites targeting vulnerable populations such as police
- Co-infections of TB and HIV/AIDS

Civil Society Support

- Capacity-building of local NGOs to implement behavior change interventions, including stigma reduction and strengthening of NGO management skills. Targeting vulnerable populations and core transmitters, such as the PNC Civilian National Police (PNC) and their families.

Social Marketing **:** activities targeting police, military, CSWs, and MSM

9.3.3 USAID Guidance on Concentrated Epidemics: Focus on High Risk Groups

According to the USAID HIV/AIDS Guidance for M&E[40], surveillance programs in low prevalence countries should focus on groups who practice "high risk" behaviors such as STI patients, commercial sex workers (CSWs), injecting drug users (IDUs), men-who-have-sex-with-men (MSM) rather than the general population (usually with samples of antenatal women). In addition, in some cases where the epidemic is "low-prevalence" or "concentrated," national level monitoring and reporting may focus only on behavior change among key "high-risk" sub-national populations. It should be noted that every 3-5 years is the minimum interval and more frequent surveys may be required to adequately monitor program progress – especially among groups that practice "high-risk" behaviors.

AIDSMARK and PASMO, recognizing that CSWs, MSM and clients of CSW are the principal populations at risk and that these populations may be the bridge for the epidemic into the general population, are expanding activities over the next two years. "Targeting high-risk populations is considered to be the most cost-effective strategy for achieving the greatest health impact and averting the maximum number of HIV infections."[41] The objectives are to reduce risky sexual behavior and increase access to condoms.

PASMO is monitoring activities through an MIS that tracks activities and sales on a monthly basis; it will be evaluating through two quantitative surveys largely supported by regional AIDSMARK funding.[42] The second survey, a behavior surveillance survey, will track the major behavior change activities critical to achieving the maximum health impact.

[40] Page 3-4
[41] AIDSMARK Scope of Work, El Salvador, 2002-2003
[42] Annex G presents proposed PASMO indicators.

SOW Question: Has USAID funding of the MOH National HIV/AIDS Program targeted resources effectively? What revisions, if any, should be made for the last two years of activity implementation?

Until recently, USAID/El Salvador HIV/AIDS activities with the MOH were not as focused or strategic as they could have been. Largely this was due to changes in MOH personnel (including Ministers) who had different priorities for addressing the HIV/AIDS epidemic. In addition, historically the MOH has not had adequate staff or equipment to address the growing HIV/AIDS problem in El Salvador.

Important results, however, from the multi-center study have recently become available, and an assessment of the Sentinel Surveillance System has been conducted by CDC, both of which have provided the Mission with important information to better plan the use of resources during the last 2 years of activity implementation with the MOH as well as other partners. Both of these sources point out the importance of having reliable information as well as systems to collect it. Lessons learned which should be applied during the two years remaining in the current strategic plan are presented as Future Directions in Section 9.4.

SOW Question Is the USAID-funded behavior change intervention targeting among men receiving enough stakeholder support to result in lasting institutional changes as well as the expected behavioral changes in police and their family members?

Two different USAID partners target men with specific interventions: PASMO, via its condom social marketing program to high-risk behavior groups including MSM and clients of CSWs, and the CHANGE project working with the PNC. Achieving behavior change is a long-term process. PASMO seems to be reaching key target groups though their social marketing program, although the MSM population seems to be harder to access than the CSWs since they are more "hidden". In addition, many of the high-risk behavior groups are most active at night, when PASMO does not have sufficient staff to adequately cover these mobile populations. Since condoms are sold, and commitment is high, there seems to be sufficient stakeholder commitment to result in lasting changes. A priority is to reach greater numbers of high risk behavior groups during the next 2 years through a PASMO "night shift"**.**

The CHANGE project, working with the PNC, is planning a baseline survey that will be extremely important in building stakeholder support for the planned behavior change interventions. Due to societal attitudes regarding certain sexual practices or behaviors, the design and application of this survey will be critical in obtaining accurate truthful information. It will be extremely important that the baseline results be shared with decision makers as well as project participants. Once training is complete and the interventions begin, lasting institutional support will be gradually achieved as decision makers and participants are able to see the effectiveness of the interventions.

9.4 Future Directions

1. USAID should prioritize the implementation of a strengthened/expanded surveillance system with the MOH and make the monitoring of the epidemic in groups who practice "high-risk" behavior a priority.

2. USAID and colleagues should develop and implement a plan for dissemination of important results regarding HIV/AIDS to increase stakeholder support.

3. Considering that some officials in the MOH may have philosophical differences with USAID about work with high-risk behavior groups, the Mission must seek out where there is common ground with

the MOH and plan its activities for the next 2 years accordingly. Although the Mission should always keep in mind interventions that are evidence-based, and if possible reflect the state-of-the-art programming, it must weigh into the equation what is realistic to accomplish within such a short period. Consider the current (conservative) environment in the MOH and develop a clear, realistic work plan for 2 years with the limited funds available on areas that can be mutually agreed upon.

4. To complement activates that the Mission is able to implement with the MOH, it should continue with its strategy to strengthen local NGOs (institutionally and organizationally) especially in their ability to expand their donor base and to promote their institutional financial sustainability.

5. USAID should make it a priority to enable PASMO to reach greater numbers of high risk behavior groups during the next 2 years by expanding PASMO staff and including a "night shift".

6. USAID and CHANGE should share the upcoming baseline survey data to build stakeholder support for the planned behavior change interventions.

10. DENGUE PREVENTION AND CONTROL IN EL SALVADOR

10.1 The Problem

In June 2002, the President of El Salvador declared a state of dengue-related emergency in the departments of San Salvador, Libertad, Santa Ana, and Cabañas, and a yellow alert in the rest of the country According to the PAHO, by June 15, the number of clinical cases of Dengue reached 1301 (an incidence rate of 20.28 per 100 thousand population), 92% (1200) of which are the classical type and 8% (101) are of dengue hemorrhagic fever (DHF). Children between the ages of 5 and 9 years are most affected. To date, six children have died, four of whom have been confirmed, while the status of the other two is currently under study.[43]

"In the past ten years the number of dengue and dengue hemorrhagic fever cases (DHF) has increased dramatically in Latin America and the Caribbean. According to PAHO, the number of reported DHF cases between 1989 and 1993 increased over 60-fold as compared to the five-year period between 1984 and 1988. In 2001, 609,000 cases of dengue including 15,000 of DHF were reported in LAC, a dramatic increase from the 66,000 cases of dengue reported in 1980. Fifteen countries in LAC have reported cases of DHF with five countries in South America reporting major epidemics. Aedes aegypti, the mosquito that transmits dengue, had been largely eradicated but has returned due to a range of factors including a lack of surveillance, poor prevention, control, and treatment programs, increased urbanization, lack of resources, and inadequate public education efforts."[44]

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[43] http://www.paho.org/English/PED/dengue_elsalvador.htm

[44] Email from Elizabeth Fox to Karen Welch, November 5, 2002. That email memo also noted: " The El Salvador dengue project currently is the only USAID funded initiative in LAC. It has been guided by global best practices and it aims to pilot a sustainable approach to dengue prevention and control in El Salvador that is cost-effective and can be managed at the community level. The results of the program can be used to expand dengue control and prevention programming to other priority dengue control areas in the country and to other countries."

"At the March 2001 State of the Art (SOTA) meeting of USAID's Population, Health, and Nutrition (PHN) officers for the LAC region, participants noted their need for more information regarding dengue fever and DHF, including its epidemiology and options for prevention, treatment, and control. In recognition of the increasing importance of dengue fever as a public health problem, the LAC Bureau has requested EHP to prepare a summary of best practices for the control and prevention of dengue. This paper will be disseminated to PHN staff in the LAC region, and may form the basis of a presentation to PHN staff during the next LAC PHN officers SOTA meeting tentatively planned for March 2003."

10.2 Partners: **CHANGE, CDC, MOH, Municipalities, UNICEF**

10.3 Activities

Objective: To prevent dengue transmission through the development of a sustainable and integrated approach for dengue control and prevention, including the participation of households, community organizations and the private sector (as appropriate). **(**$600,000 in FY 1)

CHANGE is carrying out a community-based, long-term behavior change activity in 3 communities in San Salvador, Ilopango, and Soyapango. These communities were selected because of their high level of dengue incidence. The project was launched in March 2002. Activities to date have included:

- Formative research in the communities to explore current perceptions, norms and practices related to dengue infestation and control as well as the ecology of the area.
- Development of a communications campaign that included public service announcements and massive distributions of stickers. The campaign promotes key preventive behaviors among community residents including the use of bleach and/or detergent to clean household water containers (la Untadita), covering household water containers and the introduction of fish that kill the mosquito larva into water containers.
- The application of a behavior change approach (Negotiation for Improved Practices- NEPRAM) that invites householders to try new behaviors, adapt as needed and provide feedback.
- Training of MOH personnel in the municipalities where the project is based.
- The selection and training of volunteers in each community on the NEPRAM approach.
- The development of a training manual for the community volunteers and for technicians.

10.4 Achievement of objectives

USAID will use the following indicators to assess achievement of objectives:

- Numbers of promoters trained, number of materials produced, number of radio spots, etc.
- Increased knowledge among community members
- Increase in preventive household practices (la Untadita), covered water tanks, purchase of bleach, etc.
- Impact on the levels of infestation of the vector
- Incorporation of the NEPRAM methodology and la Untadita into the implementation strategy of participating agencies (e.g. MOH, Municipalities)
- Use of larval index

The evaluation protocol includes a case control study with application of a survey (on knowledge and practices), interviews and focus groups.

Positive aspects of the project

1. Promotes community self-sufficiency (in the past, depended on the MOH to apply abate (insecticide) and fumigate)
2. Cost-effective – accessible to most community residents
3. Community organization/participation
4. Trained 260 personnel of MOH
5. Support from MOH (have not been successful with their chemical approach to dengue emergencies)
6. Can multiply in surrounding communities in San Salvador

Unanticipated effects.
The project is now initiating the community intervention due to a two-month delay and the dengue emergency declared in July, 2002. In response to the emergency, the project needed to accelerate the workplan and adjust some of the original objectives. In addition, one of the original communities selected (and where the baseline research was conducted) was changed in this planning process.

SOW Question: Are MOH and CHANGE dengue prevention and control activities well-coordinated and sufficiently inclusive of the partners needed to mobilize communities?

The primary project partners are the municipality and the MOH. Based on interviews with the staff at the MOH in San Salvador, they are committed to the project and its success. During one community visit, representatives from both the alcaldia and the MOH had a very effective interchange with community residents. It would be important for the MOH to be actively involved in project implementation, e.g.,- in regular refresher sessions for the promoters, etc.

The MOH, UNICEF and ASDER (a national Salvadoran radio network) are also involved in the production of educational material on alternative approaches to dengue prevention such as the Untadita intervention which also involved training, community mobilization, and household visits. CHANGE led this initiative. There was originally the idea of including students at the bachelor level in community mobilization activities. This may be a useful avenue to pursue to increase the activity at the community level.

10.5 Future directions to Consider

1. Consider inclusion of a behavior change indicator for dengue control in the USAID results framework.

2. Consider a no-cost project extension**:** Based on the current project timeline, it would be difficult to achieve the desired changes at the community and institutional levels by March 2003. With a longer timeframe, the project may be able to demonstrate a cost-effective, community based approach to behavior change at the community level as well as institutionalization within the MOH.

3. Finalize the evaluation protocol with clear and measurable behavioral and entomological objectives at both the community and institutional levels. The evaluation protocol should reflect specific, measurable objectives and a timeframe for monitoring progress. Given the project time frame, it would be important to clarify evaluation indicators for the short (by March, 2003) and medium-term (in view of a potential project extension). While indicators such as the number of people trained and documents produced reflect that activities are in progress, they do not represent achievement of the overall project objectives. In terms of the MOH, it would also be useful to clarify indicators for institutionalization. What would that look like? Would inspectors recommend la Untadita instead of or in conjunction with chemical interventions?

4. Ensure solid documentation of entomological data (change in number of larvae) and behavioral indicators. Since the project is introducing alternative interventions when the emphasis has been on chemical approaches, ensure that there is a strong evidence base to demonstrate the efficacy of la Untadita and the NEPRAM approach and advocate for wider dissemination.

5. Work closely with the MOH staff that has been trained. Try to incorporate the MOH staff in project implementation and work with them on plans to apply their new knowledge on the job. They must be

using their new knowledge or it won't be retained or valued. If possible, involve the dengue inspectors (or keep informed).

6. Strengthen the environmental health component of the project. The project was originally conceived of as part of an overall approach to environmental health in the community. Behavioral approaches to dengue prevention focus on safe water storage, proper waste disposal and treatment of community sources of larvae infestation (e.g. stagnant water in old tires, discarded containers, etc.). In fact, at the community level, dengue is not the problem of highest priority. This was confirmed in the initial formative research. Greater concerns are garbage disposal and access to water. Especially as the epidemic declines, it would be important to sustain community interest and participation in cleaning and covering water supplies as part of a community clean-up campaign- and to prevent an epidemic next year. Effective linkages can be made between USAID's dengue intervention and the water and sanitation program to strengthen the environmental health component of the project.

11. CROSS-CUTTING ISSUES

11.1 Adolescents

11.1.1 Adolescents: A Nation's Capital and a National Concern

Adolescents are 34.4% of El Salvador's population; they are the nation's future and a source of concern, as the following data indicates.

- First sexual intercourse – increasingly younger
    - 7% of pregnant teens had first intercourse at age 10-14 (up from 5% in 1999) (PRIME)
    - average age for girls was 16 years (SDA study 2002)
    - 31% of girls 15-19% had had intercourse; 10% of girls had had intercourse younger than 15 years (FESAL 1998)
    - 69% of girls who had had intercourse in the last year suspected, at one point or another in the last year, that they might have been pregnant (SDA)
- Adolescent use of Contraception
    - Married/in union – 33.4% (FESAL)
    - Related to socio-economic level (62% in AB, 53% in C and 35% in D) (SDA)
- Hospital delivery
    - Adolescents an increasing percentage of women delivering in MOH hospitals (21% in 1997 to 34% in 1999)
- Adolescent maternal mortality
    - Rising adolescent maternal mortality in MOH hospitals – from 1997 to 1999, rising as a percentage (3% to 25%) and in absolute numbers (1 to 9)
- Adolescent HIV/AIDS
    - 37% of completed calls to HIV/AIDS hotline were from adolescents
    - 19% of HIV/AIDS cases are 15-24 years old
    - 22% of teens interviewed by SDA didn't know even one method to prevent HIV/AIDS
- Adolescent education
    - 1998, 30% of 14 year olds were not in school; 29% were in a grade lower than expected
    - 1997, average level of schooling = 3.07 grades
    - 64% of girls under 15 years, first pregnancy, were neither studying or working (FESAL); 59% for girls 15-19

TABLE 13: PRIME Studies of Adolescent Pregnancies in Sonsonate, Usulatan and La Paz			
	Sonsonate (N=221)	Usulatan (N=155)	La Paz (N=263)
% 10-14 Years	9%	10%	4%
% single (not married or accompanied)	18%	12%	7%
% who left school for economic reasons	35%	35%	30%
% who left school due to parents wishes	15%	15%	35%
% who had previously used FP	22%	17%	10%
% who intend to used FP after delivery	80%	83%	83%
% currently housewives	93%	87%	85%
% who would like to learn a trade	91%	76%	87%

11.1.2 Achievements

Adolescent Friendly Services

This MOH approach was mentioned in Section 8.4. PRIME data indicates considerable success over the two-year period from 1999 to 2001, due to the MOH staff in the pilot hospitals and to their outreach and collaboration with promoters and parteras in the neighboring communities:

- the percent of pregnant adolescents who received prenatal care prior to delivery in a hospital increased from 67% to 80%.
- the percent of pregnant adolescents who had used family planning prior to this pregnancy increased from 25% to 45%; among those who hadn't used FP, the percent who didn't know about FP dropped from 43% to 17%.
- The percent of teens who intended to use FP after this pregnancy was 90% in La Paz, 80% in Sonsonate and 83% in Usultan

SDA IEC with Adolescents

The ADS Adolescent Program using the present program model, a model of peer facilitation of in-school youth and their parents, has been operating since 1993. The program operates in about 10 schools in San Salvador per year: many of the schools involved take part in the program year after year; there have been about 20 schools in total involved in the program since 1993. The schools are chosen in the main for the level of poverty of the students, and because the schools want to be involved in the program. Each year groups of 20 students are named by each school to go to ADS for four days to be trained as facilitators for the Adolescent Program - a total of about 200 students being trained as Adolescent Program Facilitators each year, with a total of approximately 1,400 students trained as facilitators since 1993, and an estimated 18,000 students per year being influenced by these facilitators upon their return to their school(s).

SDA had developed a variety of handouts and IEC materials on adolescent sexuality including its risks: the risk of pregnancy, of sexually transmitted infections and HIV/AIDS

SOW Question: How do results gained from USAID investments in adolescent health at the MOH differ from results gained from USAID investments in adolescent programming at SDA?

It is not possible to compare "results" (outcome), in light of USAID investments, of the two programs because the two programs are totally different. Moreover, the SDA program, which began in 1993, has never been evaluated[45]; results from the MOH/PRIME program, which began

[45] Reportedly, the last time that SDA tried to do a pre-and-post test of knowledge, there was a backlash from the Church (read Opus Dei), and hence SDA called off the evaluation.

in 1999 and which have been evaluated, are those of a pilot. However, it is possible to compare objectives and strategies of the two programs. That comparison is in the TABLE below.

TABLE 14: Two Different Adolescent Programs		
	MOH/PRIME	SDA
Objectives:	Improve the quality of attention provided to adolescent girls in hospitals A second activity are youth clubs; PRIME is just validating a manual for health staff to use with "promotores juveniles de salud"	Train adolescent facilitators for high school programs of adolescent health and sexuality, including prevention of pregnancy, STIs and HIV/AIDS.
Institutional auspices	Ministry of Health	Ministry of Education
Geographic focus	Rural Usulutan, Sonsonate and La Paz	Urban San Salvador
Program location	Health facilities and communities	schools
Gender focus	Primarily girls (maternal health), but also boys in youth groups at Unidades	Boys and girls
Educational level of teens	1999: 87% had a primary school education or less 2001: 79% had a primary school education or less	In high school

Both programs serve important national objectives. The MOH program seeks improve the quality of attention provided to adolescent girls in hospitals, thereby motivating them to deliver within a hospital, with its attendant lower maternal and neonatal mortality rates, and with its accompanying counseling on postpartum and neonatal care, as well as family planning. The SDA seeks to motivate San Salvador youth, who are at relatively high risk for STI and HIV/AIDS (relative to youth in rural departments), to abstain from early sexual relations, or to protect themselves if they do not abstain.

11.1.3 Future Directions to Consider

1. Fund the MOH-developed manuals that have also been endorsed by the Ministry of Education and the National Secretariat for the Family;
2. Make adolescent reproductive care a priority in the seven USAID-focus SIBASIs;
3. Find a way to evaluate the SDA adolescent program; and
4. In the next strategy, consider investments that give poor rural girls a vision of a better life – more schooling or vocational education a chance to "get a life".

11.2 MOH Health Promoters

11.2.1 Background

USAID started funding health promoters in the 1970s to promote community. There are currently 1715 MOH health promoters' positions (salaried workers); 1630 are outside of San Salvador. Responsibility areas include: maternal, pre-natal and post-partum, child health (perinatal and under 5), FP, prevention and management of ARI, prevention and management of diarrhea, immunization and water and sanitation, wastewater management. Most promoters live in or near the community they serve, have a 9th grade education (on average), are both men and women, and well-accepted by the community. Theoretically, communities to be covered by a health promoter are decided upon on the basis of: distance from health center, distance from nearest full time physician, distance to water source, and number of children under 5 years in the community.

There have been tremendous achievements in upgrading and redefining the role of the health promoter by BASICS, in collaboration with the MOH.

- ✓ A new role for the promoter has been defined and attractively presented in the document, "Occupational Profile of the Health Promoter". The document includes the equipment that should be provided to promoters.
- ✓ All of the health promoters have been trained on IMCI and are applying it with the checklist and materials produced by BASICS II. In effect, health promoters are the back bone of community-based IMCI.
- ✓ The supervisory system had been non-existent. Officially, medical personnel at the health center were responsible for promoter supervision. In practice, they were fully occupied in their clinical practice and the promoters were completely isolated.
- ✓ An excellent system for supervision of the promoters has been outlined and presented in the document, "Manual for Supervision that Orients the Promoter". A new paradigm for supervision is defined as a two-way process for *orienting* and helping the promoters achieve their full potential; the protocol calls for a monthly meeting between the supervisor and health promoters

11.2.2 The Promoter, Maternal Health and Family Planning

The health promoter is essential to maternal health and family planning; he/she complements the health system by visiting women furthest away from health facility.[46] 80% of rural women in El Salvador knew about the health promoter; of the 20% who didn't know of a health promoter, 34% were between 15 and 19 years old. Exposure to a promoter had a positive health impact on family planning, reproductive health and child health. There was a strong association between exposure to a promoter and use of reversible methods and a positive association with prenatal care.

Health promoters can and should be educating women, their families and communities about possible complications of pregnancy, EOC and the importance of delivery by a trained provider. As mentioned in Section 8.4.2, Unidades, promoters and parteras should be working with their local communities on effective referral systems and delivery plans that realistically link women with trained providers, including means of transport and payment of fees.

However, weaknesses in training, supervision and logistics systems result in problems:

- Promoters feel overburdened, with too many clients, too many responsibilities and a lack of supervision.
- There is a continuing need for training promoters in family planning; nationally, 9.5% had not been trained in a recent study. In the central zone, 16% had not been trained.[47]
- According to a recent study, only 75% (range 55.5% in Zona Occidental to 87.9% in Zona Paracentral) of promoters were providing contraceptives.[48]
- There are chronic problems with insufficient contraceptives, as noted in Section 8.4[49].
- There is a need for greater support (design of referral systems, training, supervision and IEC materials) so that promoters might be effective agents working to increase the percentage of deliveries by training providers.

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[46] Assessment of health promoter effectiveness by PRIME

[47] Ramirez, Esmeralda and Luz Elda de Aguirre, *Informe Tecnico Sobre Resultados de Evaluacion Programa de Planificacion Familiar*, MSPAS, Agosto de 2002

[48] IBID

[49] A PRIME study (April 2000) indicated 85% of promoters had condoms, 65% orals, and 47% injectables. Study identifies a number of obstacles promoters face: inconsistent and insufficient stocks, Unidad support for promoters serving only follow-up clients, doctor/nurse opposition to provision of injectables.

11.2.3 The Promoter and Infant/Child Health

As indicated in Section 7, 100% of health promoters have been trained in IMCI. Training has begun on the identification of danger signs in a newborn.

11.2.4 NGO Health Promoters

SDA has 700 rural promoters who are volunteers but earn modest sums on the sale of contraceptives. Their principal job is family planning, but they also make referrals for other health services, such as prenatal care, postpartum care, deliveries and child health. Additionally, there are other promoters in the community working through cooperative agreements and NGOS; all of these promoters should be collaborating with the MOH promoter and the local Unidad. In one community the Review Team visited, such collaboration was not apparent.

11.2.5 Future directions to Consider

1. Pursue the need for additional supervisors**.** 110 supervisors have been trained of the approximately 200 needed to effectively supervise the 1715 promoters that have been trained and to guarantee an adequate supervisor / promoter ratio. Members of clinic staff have been assigned supervisory responsibilities to fill the gap- not a workable solution based on prior experience. Resolution of this problem will require the identification of available positions in the system as well as additional resources. In the interim, the MOH is trying to guarantee at least 3 supervisors per department. At present, some departments only have 1 supervisor (e.g. San Miguel, Usulatan, Sonsonate).
2. Try to ensure that supervisors are adequately supervised**.** A system is in place but has not been implemented. BASICS estimates that currently about 10% of all trained supervisors are using their new skills. Over the past few months, they have constantly been pulled from their tasks for emergency response.
3. Develop and implement a plan for continuing education on IMCI and RH/FP for health promoters and on supervision. There will always be the need to train new promoters (and supervisors) and to upgrade existing skills.
4. Evaluate the workload of the health promoter. The promoter still has a very ambitious workload and will continue to be pulled from the job to respond to emergencies and high priority public health issues. Further prioritizing may be needed to ensure compliance with essential tasks (e.g. maternal and child health and maintaining accurate records of mortalities).
5. Review system for equipment distribution, including motorcycles to supervisors. This is a limited sample, but during the field visit, the health promoter identified the need for equipment and supplies that he should have access to. USAID purchased motorcycles for supervisors to facilitate regular visits to their promoters. To date, they had not been distributed.
6. Ensure that all promoters have been trained in family planning counseling and provision and that all have adequate supplies of temporary methods and know where to refer for permanent methods – the MOH should move forcefully to ensure that SIBASIs and Unidades provide the necessary contraceptives, training and supervision for CBD.
7. Provider greater support (design of referral systems, training, supervision and IEC materials) to promoters on maternal health so they might be effective agents working to increase the percentage of deliveries by trained providers.

11.3 USAID/El Salvador Customer: the Rural Poor

11.3. 1 USAID/El Salvador Customers

The USAID/El Salvador Plan, *Sustainable Development & Democracy in El Salvador 1997-2002* states "the Mission is targeting as its customers Salvadorans in rural areas living in poverty, both relative and extreme." The plan goes on to say, "Using demographic, economic and other characteristics as criteria of need, the Mission has rank ordered geographic areas to identify where the neediest populations reside. The map of the neediest areas demonstrates the poverty is most acute in rural areas. While USAID customers live in all rural areas, there is a concentration in certain parts of the northern and eastern sections of the country."

11.3.2 Rural Poor in Seven SIBASIs

There are two challenges to targeting the rural poor. The first is to define who is poor and the second is to define who is rural. The dilemma is that there is not consensus on a definition of either. An USAID/El Salvador report *Measuring Rural Poverty in El Salvador: USAID and Other Contributions* presents a good analysis of the subject. It breaks out urban poverty and rural poverty for each of El Salvador's fourteen departments, with data from the Ministerio de Planificacion y Coordinacion del Desarrollo. Other Tables present World Bank, UNDP and FUSADES data on poverty and human development indicators. Although the data on one department differs from one source to another, all sources are unanimous about which departments are relatively the poorest and which are relatively the better off.

The report notes, however, that the definitions of rural and urban of the Ministerio de Planificacion y Coordinacion del Desarrollo[50] do not agree with definitions used by the Direccion General de Estadistica y Censos (DIGESTYC), which provides the household census data for the FESAL. FESAL, using DIGESTYC data, identifies urban and rural areas of 13 departments and five urban zones for the fourteenth department, San Salvador.[51] The MOH, using DIGESTYC data, has published data on the rural and urban population of each department, by population cohort, in *SIBASI Segun Caracterization Sociodemographica 2001*. DIGESTYC data is the source of the following Table 16 that presents the rural population of infants, children <five years, adolescent girls, and women 20-49 years in the seven USAID-focus SIBASIs.

TABLE 15: Rural Population by USAID-priority Groups, by USAID-focus SIBASI

	total population, urban and rural	rural population			
		infants, <1 year	children, 1-4 years	women, 10-19 years	women, 20-49 years
Suchitoto	182,415	193	743	800	1,472
Cojutepeque	16,359	637	2,447	2,633	4,850
La Paz	296,145	5,347	21,278	21,478	40,165
San Vicente	164,670	1,890	7,352	7,469	14,644
Jiliquilisco	67,177	710	2,809	3,011	6,482
Usulutan	195,339	2,096	8,275	8,793	18,891
San Miguel	331,683	3,982	15,546	16,074	34,302
Total	1,253,788	14,855	58,450	60,258	120,806

Source: SIBASI Segun Caracterization Sociodemographica 2001

[50] This Ministry no longer exists.
[51] FESAL 1998, page 394, Tabla A-1

SIBASI data indicates El Salvador has a total rural population of 2,641,987.

- The total rural infants, children and women ages 10-49: 1,179,214
- Total rural infants, children <5 and women ages 10-49 in USAID-focus SIBASIs: 254,369

Table 17 in ANNEX H, using Ministerio de Planificacion y Coordinacion del Desarrollo data on urban and rural poverty and FESAL 1998 statistics on health status, presents key population and health indicators for the entire country. Through the seven SIBASIs, USAID will directly reach about 21% of El Salvador's rural infants, children <5 and women ages 10-59. USAID will be focusing on one of the four Departments (San Vicente) with highest absolute poverty; one of the six (Cuscalan) with lowest percentage of hospital deliveries and two of the five (Cuscalan and San Miguel) with lowest rural CPR.

In as much as the Mission's "customers" are the rural poor, it is essential that there be "scale up" from the relatively limited (254,369) number of rural infants, children <5 and women in USAID-focus SIBASIs with the remainder of the country and with those departments and SIBASIs with the lowest indicators of health status.

11.3.3 Future Directions to Consider

1. Share important lessons learned in Sonsonate, one of the poorest departments in the country and an early implementation site for BASICS II and a department with PRIME activities in PAC/PP, adolescent health and quality improvement (COPE), with health staff in the seven USAID-focus SIBASIs.
2. Share lessons learned about targeting the rural poor in the seven SIBASIs with the MOH, the other twenty-one SIBASIs and other donors.
3. In a future Mission strategy, should the Mission reaffirm a customer focus on the rural poor, consider a realignment of SIBABIs among donors so that USAID might more fully focus its efforts in health on the rural poor.

11.4 Sustainability

11.4.1 Health Reform:

Health reform and all its related components, such as planning, financing, information systems, surveys and analysis, and coordination, will continue to be the most critical area for sustainability. The Review Team is concerned that the plan for SIBASIs may be a temporary design of the present government, which could be subject to change. Support for the MOH efforts to establish the legal framework and financing mechanisms to put the SIBASI system firmly in place is essential.

USAID funding will probably be reduced in the near future as worldwide needs increase. Therefore, the Review Team urges USAID/PHN to begin now to focus on future assistance to El Salvador in the field of health, and decide how the focus can be narrowed and the effort concentrated on key health problems whose support can greatly affect outcomes. Such a focus would require a narrowing of health assistance areas and dropping some "targets of opportunity."

11.4.2 The Rural Poor

The SIBASI model as currently envisioned does not tackle the difficult issue of how to sustainably finance health care for the rural poor. It must address this issue in order to succeed.

11.4.3 Contraceptive Security:

Throughout the world USAID has learned that one important factor in assuring sustainable family planning access and quality is a healthy market segmentation with the public, private and non-governmental sectors each playing a role so that national needs are met. TABLE 18 presents the growth of coverage from 1993 to 1998 in urban and rural areas, by the three main sources of contraception: the MOH, ISSS and SDA. The private for-profit sector is part of "other sources" and is significant only in urban areas.

TABLE 17: Contraceptive Coverage, by Area, Year and Source (%)

	total		urban		rural	
	1993	1998	1993	1998	1993	1998
MWRA using	53.3	59.7	61.3	67.8	45.6	51.2
MOH	26.1	28.1	25.7	26.7	26.5	29.7
ISS	7.7	10.9	11.6	16.2	4.1	5.3
SDA	8.1	9.3	7.5	9.5	8.8	9.1
Other sources, including commercial	11.4	11.4	16.5	15.4	6.2	7.1

Note that although CPR grew six points from 1993 to 1998, the private sector did not share in that growth. In 2001, the Commercial Market Strategies Project noted that the private sector was shrinking and that pharmacies, in particular, as a source of supply for contraceptives, had declined by 37.6% from 1993 to 1998.[52] Expansion of the private sector in the provision of contraception is essential to the long-term sustainability of the national program.

12. UNRESOLVED ISSUES/FUTURE DIRECTIONS

12.1 A National Plan

The Review Team believes that a national plan in the MOH that identifies and integrates the contributions of various donors in MCH into one plan would be immensely useful. It could:

- Ensure that all departments are adequately covered
- Highlight innovations and lessons learned in one department so that other departments, assisted by other donors, might benefit from the experience
- Ensure that new activities meant for national impact, such as standards and protocols, do have effective national coverage.

12.2 Hope for a Better Life

Section 10.1 of this report expressed concern about adolescent pregnancy. Certainly, it is essential to provide family planning information, education, counseling and services to prevent early unwanted pregnancy. The nation, however, must do more than that – it must give poor young girls a reason not to become pregnant. What might that reason be – school? Vocational training? Delaying pregnancy to stay in school or learn a trade would be a wise choice – if that choice were available to them. PRIME's data on the desire of pregnant adolescent girls to learn a trade demonstrates the hope for such an option.

El Salvador and its donor friends must find a way to invest in the education and development of adolescent girls so that they can indeed have options and choices for a better life.

[52] Commercial Market Strategies Project, El Salvador Assessment, May 25, 2001, Deloitte Touche Tohmatsu et al.

Portfolio Review of USAID/El Salvador Health Office

Annexes

Table of Contents

ANNEX A: SOW

PORTFOLIO REVIEW SCOPE OF WORK
USAID/El Salvador Health Office
September 18, 2002

1. BACKGROUND AND PURPOSE

Under the current USAID El Salvador Mission strategy, the Health Office aims to achieve the Strategic Objective "Health of Salvadorans, Primarily Women, Youth, and Children, Improved" [see Annex A: Strategic Framework]. The original timeline for achieving this objective and intermediate results was five years, or from 1997 to 2002. However, after the devastating series of earthquakes that occurred in 2001, USAID Washington approved a two-year extension for the current Mission strategy.

To facilitate an improved implementation of the two-year extension of the current strategy, the Health Office requests an external review of the current portfolio of activities. This review, or assessment, will help the Mission determine the best approach to further improve the health of Salvadorans. Specifically, the review will serve as a mid-strategy management tool, informing the Mission of the efficiency, impact and sustainability and adequacy of the present portfolio scope.

The portfolio review will note progress and constraints in implementation, assess the likelihood of achieving strategic objective and activity results, and report lessons learned to date.

2. PARTICIPATION

The portfolio review will be carried out by a team of public health advisors with expertise in the topic areas reflected in the Mission's Health Office portfolio of activities. These team members, all of whom are USAID/Global Bureau for Health employees or contractors, are senior-level health professionals experienced in assessment for strategic planning purposes.

The team will be led by a POPTECH consultant (funded with Mission field support to POPTECH), whose estimated *level of effort* required is 48 days, broken down as follows: 10 days for planning outside El Salvador, 19 days in El Salvador (based on a 6-day work week including 2 travel days), and 19 days finalizing the report outside El Salvador. The Team Leader will possess the following *qualifications*: fluency in English and proficiency in Spanish; experience in leading assessment teams for strategic planning purposes; demonstrated analytical and writing skills.

Comment: POPTECH will propose level of effort once they have review draft SOW.

The following USAID Washington staff will participate as team members:

Mary Vandenbroucke, GH (x.4758)
Elizabeth Fox, GH/HN/CS (x.5777)
Karen Cavanaugh, GH/HN (x.5859)
John Austin, GH/HN/EH (x.5763)- will participate from Washington DC

Participation by these team members will be funded by their own program support, or in the case of Karen Cavanaugh, by Mission OE.

USAID/El Salvador health officers and activity managers will participate in the portfolio review, along with implementation partners [see Annex B].

3. METHODOLOGY

The portfolio review team will employ rapid appraisal techniques such as document reviews, direct observation, and key informant interviews involving stakeholders and partners. For the document review, see Annex C for a list of reference materials. The review will address the elements described in Annex D: *Essential Elements of Portfolio Review Report*.

4. SCHEDULE AND DELIVERABLES

The *timeframe* for the Team Leader's tasks and delivery of products is:

1. September 30 to October 11, 2002 - Review documents and conduct team planning with AID/Washington-based review team and coordination with USAID EL SALVADOR Health Office.

    - Product 1.1: Draft an itinerary of site visits and interviews in El Salvador required for the portfolio review and send to USAID/El Salvador by October 9.

2. October 14 through November 2, 2002 - Lead portfolio review team in carrying out site visits, interviews, and further document reviews in El Salvador.

    - PRODUCT 2.1: Finalize work plan with review team, which includes table of contents for final report. Submit for approval to Health Office by COB October 17th.

    - Product 2.2: Prepare and present brief (20 minute) PowerPoint presentation for Mission staff that summarizes the preliminary findings resulting from portfolio review. Draft presentation should be submitted to Health Office by COB October 30. Presentation will take place on November 1.

    - Product 2.2: Lead team in drafting report, and present first draft report to USAID/El Salvador by COB October 28TH and near-final draft report on November 1, which reflect comments from Health Office, Strategic Development Office (SDO), Water and Environment (WE) Office, Democracy and Governance (DG) Office and the Mission's "front office" (i.e., Director and Deputy Director).

3. November 4 through December 13, 2002 – Prepare final report in U.S.

- Product 3.1: The final report will contain a table of contents, a two-page executive summary, and will not exceed 50 pages. The review will state the findings and recommendations as spelled out in Annex D: *Essential Elements of Portfolio Review Repor*t. The report will be in English. The Team Leader will submit three hard copies and an electronic PDF version of the final portfolio review report to the USAID Health Office by December 13.

The Team Leader will secure USAID Health Office and Mission clearances on drafts of the report. The USAID Health Office will provide these comments to the Team Leader within 3 working days of receiving each draft.

5. LOGISTICAL SUPPORT

The USAID Health Office will support the Team Leader and review team with logistical support for carrying out activities related to the review while in El Salvador. A documentation center will be established for the review team with copies of key reference documents and studies. Health Office Deputy Director Karen Welch will serve as the team's liaison with Ministry of Health and NGO partners, and she will work with the Team Leader to finalize the team's itinerary and arrange for contracted services such as interpretation.

Health Office secretaries Gloria Oliva and Cecy Villalta will assist the team with the following administrative tasks:
- country clearances,
- meeting space,
- hotel reservations,
- motorpool assistance for airport transport and field visits (team leader will need to hire a car and driver or use taxis for transportation within San Salvador),
- access to Embassy compound and equipment (computer, printer, etc.),
- assistance with check-cashing,
- scheduling and confirmation of appointments and site visits, and
- assistance in establishing and maintaining the documentation center.

ANNEX A: SO Framework

ANNEX B: Contact Information for Key Partners

CHILD HEALTH COMPONENT

USAID/El Salvador, Licda. Margarita de Lobo
mlobo@usaid.gov
Phone: 234-1666, ext. 1228

BASICS II Chief of Party – Dra. Patricia de Quinteros
basicsal@sv.intercomnet.net
Phone: 264-7519

WATER AND SANITATION FOR HEALTH COMPONENT

USAID/El Salvador, Ing. José Antonio Ramos
Jramos@usaid.gov
Phone: 234-1230

CARE/El Salvador PROSAGUAS & PROSPERAR
Ing. Ricardo Mancía, Project Director
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ANNEX C: Information Sources

Performance data tables

Mission Strategy

Survey data (e.g., FESAL 1998, RAS-ES study, and results from Nov. 2000 partner consultations)

Annual Report

Program overviews

Strategic objective Grant Agreement and Amendments for "Healthy Salvadorans" Activity 519-0430

Previous evaluations (e.g., CARE/PROSAGUAS, ADS Sustainability Review, TB External Evaluation, HIV surveillance situation analysis)

Reports from other agencies and partner consultations

Assessment resources – "Measuring Capacity Building," MEASURE Communication Project, March 2001
(http://www.cpc.unc.edu/projects/measure/publications/special/capacity_building.pdf)

ANNEX D: Essential Elements of Portfolio Review Report

I. Review Portfolio Design

- Review all activities (i.e., contracts, grants, cooperative agreements, field support work plans) under the Strategic Objective (SO) results framework to assess: causal hierarchy of activity inputs, outputs, and intermediate results.

  Are the activity objectives directly linked to the intermediate results?

  If so, then:
  Are the activity inputs appropriate for achieving activity objectives?

- Articulation of activity elements: goal, objectives, activity outputs, activity inputs.

  Do the activity goal and objectives have indicators that enable measurement/assessment of their accomplishment?

  Are the inputs and outputs specified in quantitative and qualitative terms, with a reasonable and realistic timeframe for their delivery/production?

- Assessment of external factors.

  Are the activity designs realistic, taking into account the current social/political/economic conditions of the country?

II. Assess Activity Performance

- Factors that facilitate or inhibit implementation of activities in portfolio.

  Strategy: decisions regarding emphasis among activities, quantitative targets, regional/nationwide coverage, number of sub-activities (i.e., too many vs. too few), phasing of activities, etc.

  - Judged on the basis of activity performance, is the strategy appropriate to achieve results in the established timeframe?

  - Were activities undertaken or currently underway that were not specified in activity documents? If yes, why were they undertaken and what outputs

were produced? If they are still ongoing, should they be continued?

Planning: decision-making process on how to allocate inputs to undertake activities.

- Has activity management developed an overall implementation plan taking into account planned inputs, the activity timeframe, and the expected outputs?

- How have the various parties involved, (e.g. USAID, CAs, host country partners) been included in drawing up an implementation plan and how are their priorities reconciled?

- Has the implementation plan been followed to date? Does it need modification for the last two years of strategy implementation?

SALSA/MOH Coordinating Unit Management/Administration: practices and procedures used to implement activities.

- Has activity implementation been helped or hampered by activity organization (i.e., lines of authority, division of responsibility, job descriptions).

- How well are the following administrative tasks carried out?

  - fiscal management, including tracking activity costs, financial record-keeping
  - procurement and distribution of supplies and equipment
  - management information system
  - intra-activity communication

- What proportion of the costs of the activity is for management/administration in comparison to the operational aspects of the activity, such as provision of TA, commodities, services?

SALSA/MOH Coordinating Unit Staffing

- Are the levels of staffing adequate for current activity needs?

- Is staff qualified for their tasks (education and experience)?

- Is staff spending appropriate amounts of time on respective activities to enable achievement of results?

Performance Monitoring

- Based on the perspective gained during the present exercise, assess the accuracy and completeness of the information derived from the monitoring and evaluation activities. How can this process be improved upon over the last two years of implementation?

- How has performance monitoring been used as a management tool? How can this be improved over the last two years of implementation?

Coordination with other agencies and the government

- At what stage in the assistance process (needs assessment, program/activity formulation, activity implementation, monitoring and evaluation) and at what level (USAID other donors, government, and cooperating agencies, contractors/grantees) has coordination taken place?

- Has a lack of coordination caused problems in activity implementation, e.g., duplication of effort of different donors or conflicting activities? How can coordination be improved?

Relationship with AID

- How do activities in the portfolio relate to USAID Global Health, LAC, and other USAID Missions in Central America and by what means do these units relay their views to the activity management?

- If there have been problems in the activity due to the GOES/USAID or CA/USAID relationship, what have been their causes?

➢ Other factors that facilitated or inhibited activity implementation.

Review:

- Continuity in economy and social policy of host country

- Political and administrative support from host government

- Introduction or enforcement of relevant legislation

- Socio-economic factors, including beneficiaries' receptiveness to change, religion, role of women, etc.

III. Review Activity Effects and Outcomes

➢ Extent to which activity objectives have been achieved.

Based on the activities' qualitative and quantitative indicators, assess progress towards achievement of activity-level results.

Are there other indicators by which objectives might be judged?

Is each activity reaching its target population? If not, explain why.

➢ Unanticipated activity effects.

Were there positive activity outcomes that helped further or potentially could further the accomplishment of results?

Were there negative activity outcomes that could hinder the accomplishment of results?

IV. Specific Questions Related to Current Health Initiatives

➢ Policy and Reform.

Partners: Partners for Health Reform Plus, Ministry of Health, Management Sciences for Health, Social Security Institute, Consejo Nacional de Reforma

- Has USAID assistance (financial and technical) been sufficient to date to influence broad health sector reform?

- Has the financing and provision of technical resources through USAID funding of SALSA impacted structural changes in the MOH to date? Can they be expected to do so?

- To what extent has the decision to provide primary health care services free-of-charge affected the modernization process of the

MOH? During the SALSA period, has the MOH changed their allocation of resources to curative and preventive services?

- What level of commitment has the MOH and GOES shown toward establishing a legal environment that will support the continuity of SIBASI development and the launching of broader health sector reform? What concrete steps have been taken? What still needs to be done over the next two years?

➢ Environmental Health.

Partners: CARE/PROSAGUAS, CARE/PROSPERAR, PCI/FAMSAL, MOH, municipalities and community leaders

- Has liaison and coordination with other agencies (donor, governmental, local NGO, international NGO) and other USAID/Offices been effective? How can it be improved over the next two years?

- Are current strategies for long-term sustainability appropriate?

- Is there an adequate participation by women in community Water and Health Committees and are gender considerations being properly addressed?

- Do health education methodologies appear to be having the desired impact on health related behavior, and are adequate systems in place for measuring this?

- Is there an effective collaboration among Health Committees and the Health Promoters from the Ministry of Health, or NGO Health Promoters?

➢ Infant and Child Health.

Partners: MOH, BASICS II, MOST

- What has been the impact of the SALSA/MOH strategies: IMCI, AIN, and Mother-Baby Package on child and infant mortality? Is the MOH monitoring these strategies adequately?

- How committed to increasing exclusive breastfeeding are MOH personnel at all levels? Are activities such as breastfeeding support being monitored at the hospital level?

- What has been the impact of SALSA/MOH strategies to improve newborn care on those newborns who aren't delivered in MOH hospitals (i.e., delivered by midwives or alone, etc.)?

- Are MOH Health Promoters carrying out activities according to their new profile? Is their new monitoring and evaluation system being implemented? How is it functioning? Does the Health Promoter clearly understand his/her responsibilities?

- What role do the Rural Nutrition Centers play in improving the nutritional status of the children that attend them? Should these centers include more activities in early childhood education and infant stimulation? Has the rehabilitation of these centers led to more mothers engaging in income-generating activities while the children are attended at the centers?

- How can additional impact be achieved in infant and child health over the next two years?

➢ Reproductive Health.

Partners: Salvadoran Demographic Association (SDA), PRIME II, MOH, FHI, DELIVER, CDC, Georgetown University

- Are USAID activities supporting significant improvements in maternal health? If not, why not?

- What has been the impact of centrally-managed, *core-funded* activities in the area of reproductive health in El Salvador?

- How do results gained from USAID investments in adolescent health at the MOH differ from results gained from USAID investments in adolescent programming at ADS?

- What has been the result of USAID support for MOH and ADS in the area of contraceptive logistics and supply? Is there sufficient commitment from MOH in terms of fully implementing and monitoring USAID-funded innovations to the contraceptive logistics system?

- Given the current contraceptive prevalence rate (CPR) and the unsatisfied demand of contraceptives in El Salvador, what should be the focus of USAID's family planning program over the next two years? Where are the gaps (e.g., private or commercial sector, rural populations)?

➢ HIV/AIDS and Other Infectious Diseases.

Partners: MOH, FHI, CHANGE (AED), TBCTA, PAHO, CDC

- Has USAID funding of the MOH National HIV/AIDS Program targeted resources effectively? What revisions, if any, should be made for the last two years of activity implementation?

- Is the USAID-funded behavior change intervention targeting among men receiving enough stakeholder support to result in lasting institutional changes as well as the expected behavioral changes in police and their family members?

- Will recent USAID efforts under the MOH National TB Program activity likely lead to a sustainable program? If not, what else is needed?

- Are MOH and CHANGE dengue prevention and control activities well-coordinated and sufficiently inclusive of the partners needed to mobilize communities?

VI. Summarize Lessons Learned

What lessons can be learned from this initial strategy period that could be useful to Government of El Salvador and NGO partners in the last two years of strategy implementation?

VII. List Unresolved Issues

Briefly examine unanswered questions.

12/30/aa

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ANNEX D1: USAID/EL SALVADOR PHN POLICY AND REFORM AGREEMENTS: SUMMARY OF BASIC INF

	Agreement Period	Contractor	Level of Funding	Planned Activities/Deliverables/ Products	Actual Activities/Deliverables/ Products	Results
Pre-SALSA	1990 - 1998	Medical Service Corporation International (PROSAMI)				• Strengthe performa • Develope • Provided people • Reduced • Reduced to 3/10,0 • MOH ass NGOs • 450 rural • database • risk mapp • Formed t loans to underserv
	1994	ANSAL		Comprehensive assessment of El Salvador health sector with IDB, World Bank		• Led to na substanti • Laid the
SALSA	5/99 - 9/02 (terminated in 12/01)	TASC (MSH)	$2,628,373 (reduced to $1,726,715) effective burn rate at $54,000/month	Assist Ministry of Health to develop and implement SISAs by: • Developing administrative, managerial instruments/documents • Designing training for SISAs on these instruments/documents • Design evaluation system for quality and efficiency assessment of SISA facilities • Train departmental level M&E units and SISA personnel on research and indicators • Social control and community involvement • TA to develop sub-systems for management of equipment and supplies, human resources, promoters, maintenance, program planning Provide National Assembly public health committee with technical assistance to strengthen capacity for legislative oversight of health sector, draft and promulgate appropriate legislation for	Worked with Ministry of Health counterparts to develop and disseminate the following documents in support of modernization and decentralization: For the Quality Assurance Directorate: • Performance management contracts • Control and monitoring guide • Information system • Manual for the directorate of quality assurance For the Regulation Directorate: • Manual for the directorate of regulation • Implementation plan For the Administration and Financing Directorate: • Manual for the directorate of administration and finance • Implementation plan	• Enabled central M of regula finance a • Enabled and resp them. • Assisted health re vision. • Early ter report as comprehe planned

	Agreement Period	Contractor	Level of Funding	Planned Activities/Deliverables/ Products	Actual Activities/Deliverables/ Products	Results
				health reform through: • Quarterly workshops • International conferences and study tours • Operations research Provide technical assistance to National Health Commission for high-level, inter-institutional oversight and direction to national health reform process. Coordinate with local entities to carry out research into: Financing mechanism for health reform; Health human resources Social control and community involvement	• Payment mechanisms For the SIBASIs: • SIBASI Manual Oversight system: • Guidelines for reform • Mission and Vision statement • Models For the Planning Directorate: • Planning manual Internal Regulations • Presentation of the internal regulations. • Modifications to the internal regulations. For the strategic plan: • Strategic plan for institutional development	
SALSA	1/00-9/02 (terminated in 9/01)	Booz Allen	$1,200,000 (reduced to $950,000) effective burn rate of $45,000/month	• Develop executive health information system (EHIS) for Ministry of Health , implement in 2 SISAs, train Ministry of Health and SISA staff • Incorporate SISA dimension into the EHIS • Integrate population, epidemiological, facility and Statistics and Epidemiology Integrated System (SIEES) into EHIS • Develop national health information system (NHIS) for health statistics and outcome information from all sources including geographic information system nationwide • Train Ministry of Health and SISA staff in use of information for decision making	Proposal with options for information systems that did not satisfy Ministry of Health including: • Delegation of epidemiological information system to CDC • Determination not to integrate EHIS because existing systems out-of-date and poor quality • Proposal to implement in one SIBASI rather than 2 SISAs • Determination that NHIS is not feasible • Proposal to train only central Ministry of Health and one SIBASI staff (no departmental level, no other SIBASIs)	• Unsatisfa lack of b investme systems. predicate • MOH co assistanc USAID a transferri powerful
SALSA	11/01 – 9/03	PHRplus	$1,985,000 ($542,742 spent from 11/01 through 9/02 at effective burn rate	• **Policy**: Help Ministry of Health and other key actors at central level to strengthen health system ❖ Carry out political mapping ❖ Develop advocacy strategy	• Baseline survey of 7 SIBASIs, presentation of results to Ministry of Health and SIBASIs, 3 month action plan to	

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	Agreement Period	Contractor	Level of Funding	Planned Activities/Deliverables/ Products	Actual Activities/Deliverables/ Products	Results
			of $49,000/mo)	for normative process, policy dialogue ❖ Develop indicators for SIBASIs and help Ministry of Health apply them ❖ Help Ministry of Health program use of AID funds to support system strengthening ❖ Support Ministry of Health in promotion of rapid adoption of SIBASI best practices • **Finance**: Improve normative environment to support the function of a modernized Ministry of Health at the central and zonal levels and the development and efficient operation of SIBASIs at the local level of service delivery. • Equity analysis of NHA and survey data • Seminar series on health financing • Advocacy support to local and zonal level for best practice implementation at all levels • Operational directives for the SIBASI model and review with interested parties • **Decentralization**: Support strengthening of local capacity of SIBASIs to deliver integrated basic services to vulnerable populations. • Identification, documentation and dissemination of best practices • Communication strategies • Develop and pilot test financial management, governance, information system, hr systems for SIBASIs •	address weaknesses identified in communications and information exchange. • Planning workshop with SIBASI teams to develop action plans. • Developed more detailed indicators of a "well-functioning" SIBASI for standardized monitoring and evaluation system. • Facilitated donor meeting of CIM-R (USAID, IDB, GTZ, PAHO)	

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	Agreement Period	Contractor	Level of Funding	Planned Activities/Deliverables/ Products	Actual Activities/Deliverables/ Products	Results
SALSA	8/98 – 6/05	MOH Central Level	$3,500,000 ($746,000 spent 1/99 through 9/02 at effective burn rate of $17,000 /mo)			• MOH has organizat • MOH has care netw • MOH is structure
		SIBASIs				• SIBASIs SALSA I

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ANNEX D2: SALSA STRATEGIC FRAMEWORK EVOLUTION ON POLICY AND REFORM

Parameter	7/98 SOAG	9/01 Amendment No. 6	8/02 Amendment No. 9
SO statement	***Sustainable*** improvements in health of women and children achieved		Health of Salvadorans, ***prima*** children, improved.
Policy and reform IRs	Enhanced policy environment to support ***sustainability*** of child survival and reproductive health ***programs***		NONE
Policy and reform Sub-IRs			Policies supporting ***access to*** strengthened. Policies supporting ***use of*** hea ***practices*** strengthened.
Policy and reform Indicators	***Percent of Ministry of Health expenditures allocated to primary care.*** ***Percent of expenses recuperated by the Ministry of Health from fees charged to users at the health facilities.***	Adds "***Number of SIBASIs developed by the Ministry of Health***" Removes "Percent of Ministry of Health expenditures allocated to primary care"	Number of SIBASIs develope (collected by Ministry of Hea assistance from USAID contr
Policy and reform activities	Policies and budget allocations that favor PHC and place greater emphasis on needs of vulnerable women and children ***Improved cost recovery and cost-sharing mechanisms*** Modernization of health structures and systems More effective coordination of policies, plans and resources within the health sector.		***Establish coordinating mech and implemented under this adequate policy framework f survival and reproductive he service quality and coverage.*** Support following elements o modernization: Policies and budget allocatior greater emphasis on health ne ***adolescents*** and children. Modernization of health struc

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Parameter	7/98 SOAG	9/01 Amendment No. 6	8/02 Amendment No. 9
			More effective coordination o resources within health sector
Major policy interventions expected	1 – Development of ***legislative and*** regulatory framework with policies and budgetary ***priorities*** favorable to improved MCH care. 2 – Reform and modernization of the health care delivery ***system***. Support for new and efficient models for delivery of health services. 3 – Policy research to support reform and modernization of ***the health system*** and of health service delivery. 4 – Coordination among key health sector decision makers and among donor agencies ***to enhance effective use of health resources***.		Development ***by executive br*** framework with ***appropriate*** l improve MCH care. 1 – Reform and modernizatio delivery system ***of the Minist SIBASI*** management which r providers and recipients most ***(Monitoring and supervision procurement, supply manage financial, personnel, logistic systems, training, referral an systems)*** 2 – Policy research on: ***-municipal participation in fi service provision;*** ***-defining health care fundin -improving Ministry of Healt decentralization.*** 3 – Health reform donor coor ***IDB, World Bank*** in coordina Donors Committee supportin decentralization (***CIM-R***)

ANNEX D3: EL SALVADOR SIBASIS AND SOURCES OF TECHNICAL ASSISTANCE

SIBASI	Source of Technical Assistance
Ahuachapan	Spain
Cabanas	UNFPA, PAHO
Chalatenango	PAHO
Chalchuapa	PAHO
Ciudad Barrios	PAHO, Luxembourg
Cojutepeque	USAID
Ilobasco	PAHO, GTZ
Jiquilisco	USAID
La Libertad	?
La Paz	USAID
La Union	GTZ
Metapan	PAHO, GTZ
Morazan	PAHO, Luxembourg
Nueva Concepcion	PAHO
Nueva Guadelupe	PAHO, GTZ
San Bartolo	?
San Miguel	USAID
San Vicente	USAID
Santa Ana	PAHO
Santa Rosa de Lima	PAHO, Luxembourg
Santiago de Maria	GTZ
Sensuntepeque	PAHO, GTZ
Sonsonate	?
Soyapango	?
Suchitoto	USAID
Usulutan	USAID
Zona Norte San Salvador	Holland
Zona Sur San Salvador	PAHO

ANNEX E: EL SALVADOR HEALTH SO INDICATOR ANALYSIS

For consideration:
Link water supply and sanitation indicators more closely to international reference standards. applied by others either in the water supply and sanitation sector or the health sector.

Highlighted below are:

- C-IMCI key family practices. Refer to document: *Family and Community Practices that Promote Child Survival, Growth and Development: A Review of the Evidence*
- Vision 21 targets
- The joint UNICEF/WHO data base on water and sanitation
- The indicator guides developed by the Food and Nutrition and Technial Assistance (FANTA) Project (published in 1999).

1. **IR 1: Access to Quality Health Related Services Increased**
    a. **Indicator 1.b:** % of rural households with adequate access to potable water
        i. **Vision 21 target:** "percentage of people who lack safe water halved"
        ii. **Joint Monitoring Programme:** "percent of population with access to functioning safe water supply" (population-based data)
        iii. **Joint Monitoring Programme:** "percentage of rural water supplies functioning"
        iv. **FANTA document:** "quantity of water used per capita per day"

2. **IR 1: Access to Quality Health Related Services Increased**
   Sub-IR 1.3: Infrastructure Supporting Health Related Services Improved
    a. **Indicator 1.3.a:** # of latrines and water systems constructed or rehabilitated
        i. **Questions:** This is not a useful indicator from a health point of view, or from a programmatic point of view. This type of numerical indicator may provide some information on products resulting from funds spent, but provides no information on the use of the latrine, who uses it, and the hygienic status of the facilities. The combination of water and latrines in this context is not particularly useful.
        ii. **Vision 21 target:** "percentage of people who lack adequate sanitation halved"
        iii. **Vision 21 target:** "all schools equipped with facilities for sanitation and hand washing"
        iv. **Joint Monitoring Programme:** "percent of population served with adequate excreta disposal"
        v. **FANTA document:** "Percentage of population using hygienic sanitation facilities"
        vi. **C-IMCI Evidence Document:** "Disposal of feces, including children's feces, safely"

3. **IR # 2: Use of Health Related Services/Practices Increased**
    a. **Indicator 2.a:** Activity sites with at least a 26% reduction in diarrhea among children < 5 years old
        i. **Questions:** How is this measured? Maternal recall is consistent with the FANTA document. Epidemiological data is often unreliable.
        ii. **Vision 21:** diarrheal disease incidence reduced by 50%
        iii. **Joint Monitoring Programme:** No indicator related to diarrheal disease
        iv. **FANTA document:** "percentage of children < 36 months (EHP has also used < 60 months) with diarrhea in the last two weeks.
        v. **C/IMCI Evidence Document:** No indicator related to diarrheal disease.

4. **IR 2: Use of Health Related Services/Practices Increased**
    a. **Indicator 2.2a:** % of families washing hands after latrine use
        i. **Questions:** "% of families washing hands" is not clear. Is it all of the family? How does a family get a yes or no?
        ii. **Vision 21:** "good hygiene practices universally applied" (not useful)
        iii. **Joint Monitoring Programme:** No indicator related to hand washing
        iv. **FANTA document:** "Percentage of child caregivers and food preparers with appropriate hand washing behavior."
        v. **C-IMCI Evidence Document:** "Hands washed after defecation, before preparing meals, and before feeding children."

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ANNEX F: CONTRACEPTIVES

USAID/ EL SALVADOR REPORT ON CONTRACEPTIVE PROVISION, 1993 – 2004													
	1993	**1992**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**20**			
ADS	$240,287	$301,865	$407,043	$136,368	$0	$361,418	$244,984	$103,859	$292,089				
MOH	$167,483	$226,586	$92,383	$170,250	$543,889	$49,065	$25,605	$483,869	$381,881				
ISSS	$22,524	$63,080	$52,486	$57,302	$0	$85,324	$0	$0	$0				
TOTAL	**$430,294**	**$591,531**	**$551,912**	**$363,920**	**$543,889**	**$495,807**	**$270,589**	**$587,728**	**$673,970**				

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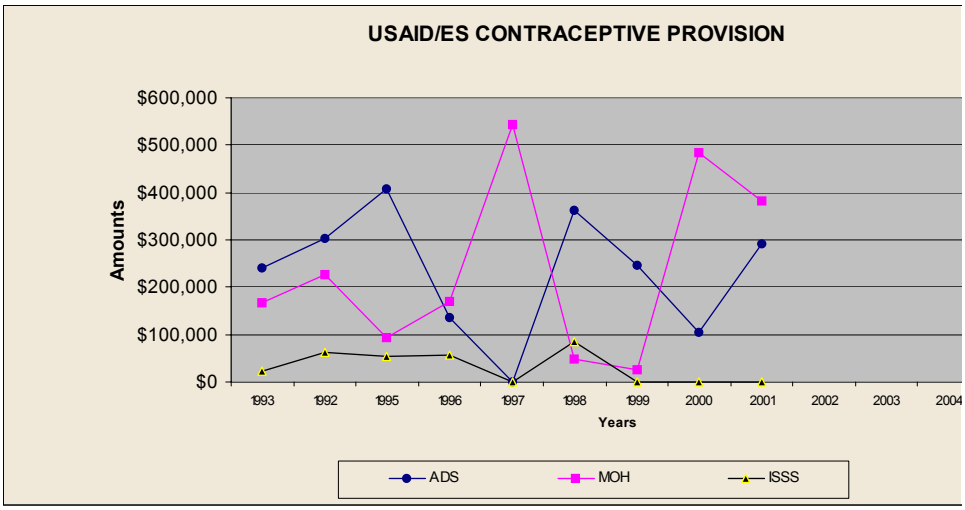
USAID/ES CONTRACEPTIVE PROVISION
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$0
Amounts
1993
1992
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
Years
ADS
MOH
ISSS

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ANNEX G: PASMO INDICATORS

OBJECTIVE 1

Approved: Preliminary Draft **Country/Organization: AIDSMark/PASMO El Salvador**

Indicator 1: Risk Reduction measured by increased use of protection by CSWs and MSM.	**2000** Target	**2003** Target
SOURCE: CSWs & MSM Behavioral Surveillance Surveys.		
1) The percent of MSM reporting using condoms in the last sex act with;		
a) stable male partner,	**36%**	**45%**
b) sporadic male partner,	**61%**	**75%**
c) all male partners, (a and b)	**24%**	**35%**
d) all partners (male and female).	**26%**	**35%**
2) The percent of CSWs reporting using condoms in the last sex act with;		
a) regular clients,	**95%**	**97%**
b) non-regular clients,	**97%**	**98%**
c) regular partner/spouse/ free union,	**27%**	**33%**
d) all clients (a and b)*	**82%**	**95%**

COMMENTS: * This figure is being verified and will be changed if it is confirmed that the baseline numbers in 1997 and 2000 were different. Percentages are adjusted for sample differences in age, level of education and residence.

OBJECTIVE 1

Approved: Preliminary Draft **Country/Organization: AIDSMark/PASMO El Salvador**

Indicator 2: Risk Reduction measured by safer sexual behavior	**2000** Actual	**2003** Target
SOURCE: CSWs & MSM Behavioral Surveillance Surveys.		
1. The percent of MSM reporting that during the lastmonth they;		
a) Penetrated a man without using a condom	**45%**	**30%**
b) Were penetrated by a man without using a condom	**41%**	**25%**
c) Had vaginal sex with a woman without using a condom	**28%**	**20%**
d) Had anal sex with a woman without using a condom	**11%**	**8%**
e) Had oral sex without using a condom	**32%**	**26%**
2. The percent of CSWs reporting that during the last month they:		
a) Had vaginal sex without using a condom	**35%**	**30%**
b) Had anal sex without using a condom	**9%**	**6%**
c) Had oral sex without using a condom	**9%**	**8%**
3. Mediam number of casual partners in last 12 months*	**?**	**?**
4. The percent of MSM reporting that they currently use lubricants	**45%**	**50%**
5. The percent of CSWs reporting actually using lubricants	**5%**	**15%**

COMMENTS: * Additional analysis is being done on the data set to establish this target. All percentages are adjusted for sample differences in age, level of education and residence.

OBJECTIVE 1

Approved: Preliminary Draft **Country/Organization: AIDSMark/PASMO El Salvador**

Indicator.3: Improved access to condoms in terms of availability & affordability.	**2001** Actual	**2002**	**2003**
SOURCE: Distribution Surveys and BSS.			
1. The percent of high-risk outlets selling condoms:	24%	28%	33%
2. The percent of commercial outlets selling condoms;	16%	19%	22%
	2000	**2003**	
3. The percent of MSM reporting that condoms are not expensive	89%	91%	
4. The percent of CSWs reporting that condoms are not expensive	80%	85%	

COMMENTS: High-risk outlets are defined as bars, clubs, brothels, motels and hotels. Commercial outlets are defined as general stores such as tiendas, supermarkets and gasoline stations.

ANNEX H: RURAL POOR

TABLE 16: El Salvador Key Population and Health Indicators, by Department												
						FESAL 1998						
Department	Department pop. 2000	USAID-targeted SIBASI	SIBASI pop. 2001	% of rural population in relative or absolute poverty*	% of rural population in absolute poverty*	CPR, MWRA	CPR, MWRA, rural	% of hospital deliveries 1998	complete immunization of under 36-month olds (%)	% of malr (heig age)		
Ahuachapan	319,781			60	28	51	48	42	67			
Santa Ana	551,221			58	26	65	57	61	80			
Sonsonate	450,116			58	19	50	48	42	75			
Chalatango	196,755			72	41	49	46	36	85			
La Libertad	682,092			54	24	62	57	48	77			
San Salvador	2,060,669			54	20	71	65	82	78			
Cuscalan	196,715			61	30	52	43	44	76			
		Suchitoto	182,415									
		Cojutepeque	16,359									
La Paz	291,575	La Paz	296,145	59	26	58	59	51	76			
Cabanas	155,803			78	51	38	29	41	76			
San Vicente	161,104	San Vicente	164,670	81	43	51	44	55	87			
Usulutan	362,380			69	35	58	52	52	82			
		Jiliquilisco	67,177									
		Usulutan	195,339									
San Miguel	479,775			69	37	52	44	56	74			
		San Miguel	331,683									
Morazan	169,912			74	41	49	47	41	79			
La Union	273,098			72	36	44	40	47	82			
total/average	6,350,996		1,253,788	64	32	60	51	58	77			

Source: Table 1, "Annex B, Measuring Rural Poverty in El Salvador: USAID and Other Contributions

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